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ABSTRACT

This volume of 12 lessons provides expert information on a variety of medical and psychological issues in rehabilitative counseling. The lessons, which may be applied toward continuing education credits, are: (1) "Integration of Psychiatric Treatment and Rehabilitation" (Jeanne Steiner, Larry Davidson, Michael A. Hoge, and Selby Jacobs); (2) "Addressing the Needs of Clients with Traumatic Injury and Alcoholism" (Charles H. Bombardier); (3) "Recent Developments in Genetic Testing and the Rehabilitation Counselor" (Joseph E. Havranek); (4) "Substance Abuse Treatment for Pregnant and Parenting Women" (Rivka Greenberg, Judith Fry McComish, and Jennifer Kent-Bryant); (5) "Ethical Issue Considerations Working with Multiple Rehabilitation Disciplines" (Irmo Marini and Bruce Reed); (6) "The Psychological Impact on Survivors of Extraordinary, Stressful, and Traumatic Events: Principles and Practices in Critical Incident Response for Rehabilitation Counselors" (Mark A. Stebnicki); (7) "Problem Gambling: The Addiction of the New Millennium" (Brian T. McMahon and Carolyn E. Danczyk-Hawley); (8) "The Vocational Expert: Qualifying and Methodological Approaches to Earning-Capacity Evaluations" (Rodney N. Isom); (9) "Latino Culture and Mental Health in the USA" (Renato Alarcon); (10) "Developing the Case Management Relationship with Seriously Ill Homeless Individuals" (Matthew J. Chinman, Peggy Bailey, Jennifer Frey, and Michael Rowe); (11) "Meeting the Psychosocial Needs of Burn Survivors and Their Families" (Shelley A. Wiechman and David R. Patterson); (12) "Promoting Adaptive Goal-Seeking Strategies in Consumers with Borderline and Related Personality Disorders" (Alan Davis). Each lesson contains references. (GCP)

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Directions in Rehabilitation Counseling

Volume 12

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Frederic Flach

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Volume Number: 12

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Directions in Rehabilitation Counseling

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Directions in Rehabilitation Counseling

Volume 12 Lesson 1

Integration of Psychiatric Treatment and Rehabilitation

Jeanne Steiner, DO, Larry Davidson, PhD, Michael A. Hoge, PhD,
and Selby Jacobs, MD, MPH

Dr. Steiner is Associate Professor, Department of Psychiatry, Yale University School of Medicine, and Medical Director, Connecticut Mental Health Center, New Haven, CT.

Dr. Davidson is Associate Professor of Psychology (in Psychiatry), Yale University School of Medicine, and Senior Clinical Officer and Policy Director, Connecticut Department of Mental Health and Addiction Services, New Haven, CT.

Dr. Hoge is Associate Professor of Psychology (in Psychiatry), Yale University School of Medicine, and Director, Managed Behavioral Health Care, New Haven, CT.

Dr. Jacobs is Professor, Department of Psychiatry, Yale University School of Medicine, and Director, Connecticut Mental Health Center, New Haven, CT.

Introduction

Psychiatric interest in psychosocial rehabilitation dates back to the era of institution-based practice before the discovery of antipsychotic drugs.[1] However, in the early stages of deinstitutionalization and the community mental health center movement, attention to rehabilitative tasks slackened. During the 1970s, coinciding roughly with the second phase of the community mental health center movement and its focus on the seriously mentally ill, psychiatric attention to the field of psychosocial rehabilitation reemerged, emphasizing services in the community for seriously ill persons.[2,3] **Beginning in the 1980s, services researchers began to provide convincing, empirical support for some rehabilitative interventions. When Congress passed the American's with Disabilities Act in 1990, aimed at ensuring the rights of persons with physical and behavioral disabilities, including access to appropriate, comprehensive care and full citizenship, it provided enormous impetus to an advocacy movement for rehabilitation and recovery. Finally, the Surgeon General's Report on Mental Health, issued late in 1999 as the first national public health statement on mental health, emphasized the heavy burden of disease (disability) associated with mental disorders and the need for coordinated treatment and rehabilitation.**[4]

The contemporary challenge for psychiatry is to achieve integration of treatment and rehabilitation within a network of community-based services. The first part of the Patient Outcomes Research Team (PORT) study of treatment for schizophrenia, based on hundreds of outcome studies, specified the essential components of evidence-based treatment including the contributions of psychosocial rehabilitation in achieving a balanced, comprehensive plan of care for seriously ill patients.[5] **The second part of the PORT study examined the success of current patterns of usual care for schizophrenic patients in two different state systems and found the actual care conformed only modestly, generally below 50%, to the standards of care recommended by the PORT.[6] Conformance was worse for psychosocial interventions than for pharmacologic treatments.**

The introduction of managed care into the public sector of psychiatric services creates urgency for reconsidering the relation of treatment to rehabilitation. Managed care seems to be of two minds about psychosocial rehabilitation. **On the one hand, managed care paradigms focus on acute medical care and potentially ignore not only the whole task of rehabilitation but also the need to integrate treatment and rehabilitation for seriously ill, disabled persons. On the other hand, one of the leading publications in behavioral managed care offers a vision of the future of service delivery, which recognizes the key importance of psychosocial rehabilitation.[7] The vision includes three principles: (1) to capitalize on the effectiveness of atypical antipsychotic drugs, which have created a new set of patient needs by more effectively treating positive and negative symptoms, as well as the associated cognitive deficits; (2) to redesign the social programs serving seriously and persistently ill people to maximize the opportunity for recovery and reintegration into community life; and (3) to galvanize the political will necessary for system change at the state and local level.** Forward-looking, psychosocial rehabilitation specialists are beginning to conceptualize and develop psychiatric disability management programs within a managed care framework.[8]

These considerations create a timely need for psychiatrists to revisit the relationship between the arenas of treatment for symptoms and rehabilitation for disabilities. Many before us have called for integration.[9–13] Taking on this task anew provides a fresh opportunity to narrow, if not bridge, the gap between the two approaches to care. In addition, taking on this task provides an opportunity for psychiatry to clarify its agenda and the roles of psychiatrists in bridging the gap. While a few psychiatrists have made essential contributions to the growth of psychosocial rehabilitation, and many in community psychiatry have built rehabilitative interventions into their practice, the average practicing psychiatrist pays little attention to the problem. Psychiatrists ought not to lag behind, as the course is being set for the future in this arena. **If psychiatrists ignore the challenge, they run the risk of being marginalized into progressively narrower roles for clinical practice, as is often the case in aggressive managed care settings in the private sector.**

To address this state of affairs, **a report of a 1999 APA Presidential Initiative Advisory Committee on Psychosocial Rehabilitation of the Severely and Persistently Mentally Ill (SPMI), based in large part on a position statement developed by the American Association of Community Psychiatrists, recommends several possible roles for psychiatrists.[14,15] These include responsibility for comprehensive plans of care, continuing education, participation in services research, and clinical and advocacy alliances with professional rehabilitation colleagues.**

This lesson will provide a summary of the history of psychiatric rehabilitation, introduce a conceptual model for the integration of psychiatric treatment and rehabilitation, and allow mental health professionals to become familiar with specific roles that psychiatrists can fill in a system of integrated care.

The Relevance of Psychosocial Rehabilitation

Psychosocial rehabilitation has been defined as "a therapeutic approach to the care of mentally ill individuals that encourages each patient to develop his or her fullest capacities through learning procedures and environmental supports."[16] Contemporary psychosocial rehabilitation incorporates a variety of personal and environmental interventions designed to help seriously ill persons cope with their disabilities and live as fully as possible in the community. **A prominent, theoretical framework for the rehabilitation enterprise is a recovery model which comprises multifaceted interventions such as social skills training, remedial cognitive training, supported employment, supported residential services, family interventions, and supported and peer-led socialization.**[3]

We accept the premise and the evidence that rehabilitative interventions, in counterpoint with treatment procedures, play an essential, interactive role in providing comprehensive care for seriously ill persons with disabilities. We believe this axiom is true not only for psychiatry but also for general medicine. In considering the relationship of psychiatry to medicine, it is useful to make a distinction between short-term and long-term disabilities, which respectively require short- and long-term rehabilitative interventions. Because psychiatric disabilities ordinarily are long-term and require long-term rehabilitative interventions, and because recovery from psychiatric illness is nonlinear, involving relapse, and often includes residual symptoms, **the tasks of treatment and rehabilitation are not sequential and segmented, but inevitably and inextricably intertwined.**

The need to address the division between the fields of psychiatric practice (diagnosis and treatment) and psychosocial rehabilitation essentially rests on a simple, clinical logic. Patients served by professionals in both camps are afflicted with disorders that are acute and intermittent, often with residual symptoms, and often severely disabling.[17,18] The integrated, comprehensive treatment of individuals with such disorders requires connecting treatment and rehabilitation models to best serve their needs. Also, recovery from the devastating consequences of an acute illness, even if a person is successfully treated and no longer experiences severe symptoms, is best supported by psychosocial interventions.

A Strategy and Roles for Psychiatrists

We use the case study of a community mental health center to describe an overall strategy and to illustrate specific roles for psychiatrists in the integration of psychiatric treatment and rehabilitation.

The Connecticut Mental Health Center is an urban, state-owned community mental health center located in a medium-sized city. It is operated through a professional service contract with a university, which provides the senior management and clinical leadership. It is the lead agency for 13 affiliated, community-based, psychosocial rehabilitation agencies which receive the majority of their revenue from the Connecticut Department of Mental Health and Addiction Services. The Center and its affiliates make up a system that annually serves approximately 5,000 disadvantaged persons with serious illness and disabilities. It provides a full spectrum of hospital and ambulatory treatments, including assertive outreach and innovative engagement programs for its target population. While the clinical teams of the Center are interdisciplinary and the Center has a rehabilitation department (traditionally concentrated on the inpatient service), few rehabilitation specialists and programs exist within the Center itself. Therefore, to coordinate rehabilitation services for the target population, the Center depends on its role as the lead agency for the 13 affiliated, psychosocial rehabilitation agencies mentioned above. These agencies provide a spectrum of rehabilitative services including a clubhouse program, psychosocial rehabilitation, social skills training, cognitive re-mediation, vocational rehabilitation, family services, clinically supported residential services, and some neighborhood-based clinical services. These treatment and rehabilitative services promote active participation by the recipient of service and are supported by several consumer-led activities, including advisory groups, a relapse prevention program, and supported socialization.

Roles for Psychiatrists:

The following sections identify five key roles for psychiatrists in the integration of psychiatric treatment and rehabilitation, illustrated by specific case examples from the Center. They include: (1) Strategic Planning; (2) Policy and Program Development; (3) Education; (4) Services Research; (5) Provision of Integrated Treatment; and (6) Advocacy.

1. Strategic Planning

Given the latent ideological and professional conflicts between the Center and its affiliated rehabilitation agencies, as well as the competition for the limited, general fund dollars budgeted by the state to support both treatment services owned and operated by the state and private, nonprofit rehabilitation programs, the Center defines the task of integration as a strategic priority and incorporates it in various iterations into its annual strategic planning and performance improvement goals. The Medical Director plays a lead role in placing this issue in front of the organization.

The Center's strategic interest in integration builds on the intellectual directions of our predecessors at the Center for the past twenty years. Several community support initiatives, including responsibility as the lead agency for the mental health service system in 1988, also support this interest.[19,20] The main significance of this long-term perspective on developing solutions to the task of integration is that it takes time and the commitment of senior leadership.

To support the strategic goals of the Center regarding the integration of treatment and rehabilitation services, the Medical Director has structured her office to address the tasks outlined below. **The Office of the Medical Director of the Center is responsible for supervising not only medical programs, including the integration of services for mental and addictive disorders, but also risk management, continuous quality improvement, and the integration of psychiatric treatments with rehabilitative interventions. The Medical Director has created Associate Medical Directors in each of the areas just mentioned, including an Associate Director of Psychiatric Rehabilitation. This physician is responsible for medical services that support rehabilitative interventions, educational programs on rehabilitation for other medical staff, services research and other scholarly initiatives related to psychiatric rehabilitation, and integrative tasks.** In this way, form follows function insofar as the structure of the office of the Medical Director follows the strategic goals and tasks of the Center, of which the Medical Director is a senior officer.

2. Policy and Program Development

An overarching task has been to develop a conceptual model of care to support our integrative initiatives and to make the clinical work for psychiatrists and other clinicians meaningful in a comprehensive system of services. We believe a new model is necessary for two reasons. **First, we need to move beyond the medical model, even if it is broadly conceived as biopsychosocial, as it does not account adequately for recovery. Secondly, the recovery model, while also inherently biopsychosocial, does not adequately address the complexity of clinical roles and postpones integration of the disabled person into society until rehabilitation is complete.** An optimal model ought to embrace everything that is important in the task of caring comprehensively for seriously ill individuals.

In this regard, professional leaders at the Center have proposed a **"life-context model" arising from seminal studies on recovery carried out in the 1980s and 1990s.**[9,21] This new model builds on a biopsychosocial model and attempts the next step in the evolution of a theoretical approach to comprehensive patient care **by taking a person's ongoing life as the unifying framework for multiple dimensions related to disorder, health, and recovery.** It is important to note that appreciation of the "person" as the basic theoretical construct within the life context model does not preclude simultaneous appreciation of common, unifying psychological or psychosocial structures, including diagnostic criteria for disorders, in people's lives. **We believe the life-context model holds potential for supporting the integration of both psychiatric diagnosis and treatment with psychosocial rehabilitation of the type we are striving to achieve.**

Consistent with another report,[22] the Center has completed the development of an agreement with our rehabilitation colleagues regarding treatment principles and a team approach to care that includes both treatment and rehabilitation.[23] A document entitled "Principles of Care and Standards of Operation" articulates a foundation for creating an integrated approach to care that encompasses both treatment and rehabilitation services.[24] In addition, this document is based on a life-context model.[9] While the document is a cornerstone for implementing the Center's integration strategy, we do not view it as a finished product in addressing the questions that confront our collaborations. Rather, we consider it a work in progress that reflects the current status of our relationships to community-based rehabilitative colleagues. One example of a limitation is that clinicians are defined as a broad, generic category, reflecting the prevailing attitude in the rehabilitation community. **Other ongoing tasks of development include need for a refined definition of the role of each clinical professional on the interdisciplinary team, which should lead to a greater appreciation by rehabilitation colleagues of the essential role of each team member.**

In defining psychiatric roles in relation to the legitimate roles of other professionals on the interdisciplinary team, psychiatrists are taking a crucial step in the definition of their own work. This process builds on previous efforts to conceptualize psychiatric roles and work related to both treatment and rehabilitation, as well as to social control, and humanistic tasks.[25,26] **With regard to psychosocial rehabilitation, medical tasks for our purposes include comprehensive treatment planning, responsibility for psychopharmacologic treatment that supports cognitive functioning and adaptation, risk management, continuous quality improvement, and specific, rehabilitative interventions such as cognitive remediation or cognitive therapy.**

3. Education of the Medical and Professional Staff

We have embarked on a series of in-service, educational seminars on psychosocial rehabilitation aimed at psychiatrists and residents as well as other mental health professionals at the Center. These seminars are based on best practices and recent evidence for psychosocial rehabilitation.[27–33] The recommendations of the recently published Patient Outcomes Research Team (PORT) for the treatment of schizophrenia[5] and related materials regarding recurrent, major depression also inform these seminars. **The seminars incorporate the life-context model to provide a comprehensive framework for thinking about psychiatric care. Throughout, we define and demonstrate the variety of roles that psychiatrists can play for the purpose of integration.** Finally, we teach specific skills such as how to develop comprehensive, integrated plans of care in everyday practice by reviewing individual cases.

A cornerstone of the education program for medical staff is a review of the evidence for rehabilitative interventions. Evidence of the efficacy of psychosocial rehabilitation is necessary not only to assure the effectiveness of these costly interventions but also to address skepticism among those who do not know of recent developments in the clinical science of rehabilitative interventions. Evidence of effectiveness exists in several domains of psychosocial rehabilitation.[27–33] Review of health services research on psychosocial rehabilitation interventions provides a solid foundation for discussions between treatment professionals and rehabilitation professionals that is based on data instead of ideology.

Medical staff have also contributed to collaboratively organized, clinical case conferences held in locations outside the walls of our Center to search for common language and shared recognition of the needs of severely ill persons with disabilities, particularly those with comorbid disorders. These conferences not only have the potential to enhance the care of the sick and disabled individuals under discussion, they also serve the purpose of considering system deficiencies in integration that are conspicuous in many of the presentations. In the process of discussing cases, the participating professionals, including psychiatrists, clarify and explain their roles and contributions to care. As such, these conferences provide an approach to interdisciplinary team building and professional role definition.

4. Services Research and Implementation of Findings

Psychiatrists at the Center serve as investigators in behavioral services research on psychosocial rehabilitation to assess the efficacy of these interventions. Some projects are innovative in design, such as a new relapse-prevention strategy based on peer-led, supported socialization. Other possible projects include a study of treatment compliance in rehabilitation settings and a study of primary medical care provided in a psychosocial rehabilitation setting. [Davidson et al, personal communication]

One innovative project aptly illustrates roles for psychiatrists. This research tests the contribution of a cognitive re-mediation program to vocational rehabilitation.[34,35] **The project combines an evaluation of cognitive functioning along with cognitive training in support of a place-and-train, vocational program. While the research design tests the efficacy of cognitive re-mediation during vocational rehabilitation, a psychiatrist plays a key role in three areas: completing the diagnostic assessment; creating comprehen-**

sive treatment plans, including the choice of the best timing for the vocational intervention; and assuring that patients receive cognitive-enhancing, pharmacologic treatments, if indicated.

Building on evidence from our own mental health services research and the findings of other researchers about treatment and recovery, we also contribute to policy development for the state Department of Mental Health and Addiction Services (DMHAS). In support of the office of the Medical Director of DMHAS, our medical staff plays a role in the development of medication algorithms for severely ill, disabled patients enrolled in psychosocial rehabilitation programs financed by the state.[36] Our Director of Clinical Services, in collaboration with the Medical Director of DMHAS, is developing recommendations based on a community survey regarding the adjustment and recovery of patients discharged into the community. More recently, several members of our staff have contributed concepts about best practices, including the integration of treatment and rehabilitation for persons with schizophrenia, the desirability of evidence-based interventions, and other basic concepts to a Governor's Blue Ribbon Commission that establishes policy goals that will guide care for the next several years in our state.

5. Promoting Integration Through Service Provision

To support the Center's strategic goal of collaboration and integration, the Medical Director has assigned psychiatrists to provide treatment in locations that move them beyond traditional office-based care. The sites include a psychosocial clubhouse, a homeless shelter, and congregate or supported independent residences. **Off-site assignment enhances the availability of the treating psychiatrists to recipients of care outside of the clinic's walls and in settings where recovery models, rather than clinical models, predominate.** The physicians participate in an interdisciplinary team approach to care, which is used in each of these settings. Virtually every aspect of the experience, including unscheduled visits, more informal clinical relationships, conspicuous rehabilitative needs, and the dynamics of relationships among the members of the team, poses a challenge to and ultimately fosters modification of narrowly conceived psychiatric roles. This promotes the process of team building, which ultimately improves the level of care provided by promoting integration at the level of the individual as well as the system.

An inevitable by-product of team building is a greater understanding by staff of the specialization of each team member who cares for an individual. Psychiatrists, while learning about the contributions of others, demonstrate their roles through discussion of treatments, playing an active role in risk management, managing and participating in quality improvement, and formulating comprehensive plans of care, including both treatment and psychosocial rehabilitation. **Eventually, when the discussions between treatment professionals at the Center and rehabilitation professionals in the community turn formally to the topic of professional roles of team members, the groundwork will have been laid for assertions about the specialization of psychiatry within the team.**

6. Joint Advocacy

We have pursued alliances with rehabilitation colleagues to advocate for expanded rehabilitation services and increased integration. **This has occurred through a local alliance, which has advocated both at the state level for joint clinical programs such as residential placements for recovering persons and mobile outreach services and at the federal level for supported housing.** Generally, the administrative and medical leaders of the Center pursue this task as part of participation in a long-standing, statewide planning process for service integration. The time spent in joint planning and the relationships established in the alliance contribute to the dialogue between the realms of treatment and rehabilitation.

Conclusions

At present, managed care is the leading paradigm of health service delivery both in the private and public sectors. In its formative years during the early 1980s, managed care entrepreneurs borrowed wholesale concepts and clinical program strategies from community psychiatry.[37] With managed care now in transition again, with growing evidence of the efficacy of community-based psychosocial rehabilitation, and with the recent publication of convincing recommendations about best practices for the seriously mentally ill, we believe the challenge of integrating treatment and psychosocial rehabilitation is reemerging as a central task for psychiatry.

In our case study of an urban community mental health center, we have tried to illustrate how psychiatrists can renew their commitment to better integration of the theory and practice of psychiatric treatment with psychosocial rehabilitation. We have described six key roles that psychiatrists can play in this endeavor, which can foster our sense of professional identity in this era, and enhance the level of care for the seriously ill.

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Questions Based On This Lesson

To earn CE credits, answer the following questions on your quiz response form.

1. **The need for integration of psychiatric treatment and rehabilitation is underscored by the concepts outlined in the:**
   - A. Americans with Disabilities ACT of 1990.
   - B. The Surgeon General's Report on Mental Health of 1999.
   - C. The Patient Outcomes Research Team (PORT) studies.
   - D. All of the above

2. **Rehabilitation for patients with serious mental disorders is best carried out:**
   - A. When symptoms have been stable for a period of six months.
   - B. After full remission of psychotic symptoms is achieved.
   - C. In conjunction with treatment of active symptoms.
   - D. When symptoms have been stable for over a year.

3. **A "life-context model" of conceptualizing psychiatric disorders implies that:**
   - A. Physicians should not play an active role in assessing quality of life issues.
   - B. Improvement of psychiatric symptoms and functional impairments can take place in multiple spheres over varying time courses.
   - C. Psychiatric symptoms are not related to biologic abnormalities.
   - D. Psychiatric symptoms should be treated as separate from other contexts of a patient's life.

4. **Managed care companies are becoming more interested in psychiatric rehabilitation because:**
   - A. There is evidence that psychosocial rehabilitation can decrease morbidity and increase levels of function among patients with psychiatric disorders.
   - B. Rehabilitation services are less costly than medical treatment.
   - C. There have been no advances in the pharmacologic treatment of psychiatric disorders in recent years.
   - D. Rehabilitation is more effective than all other psychosocial interventions.

Directions in Rehabilitation Counseling
Volume 12 Lesson 2

Addressing the Needs of Clients with Traumatic Injury and Alcoholism

Charles H. Bombardier, PhD

Dr. Bombardier is Associate Professor, Department of Rehabilitation Medicine, University of Washington School of Medicine, Seattle, WA.

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Introduction

Alcohol is arguably the most used and abused drug in the United States. While most people manage to use alcohol safely without incurring significant harm, 1 in 10 American adults has significant problems related to their use of alcohol.[1] This lesson will show that alcohol use and abuse are of particular concern among people with acquired disabilities and that rehabilitation professionals should, therefore, become more knowledgeable about these issues. Rates of preinjury alcohol problems are particularly high among persons with traumatic injuries, including traumatic brain injury (TBI)[2] and spinal cord injury (SCI).[3] Therefore, TBI and SCI will be used as examples of disabling conditions in which alcohol-related problems play a significant role. The links between alcohol problems and these two forms of acquired disability will be described in terms of the prevalence and effects on outcome. The lesson will describe the major ways alcohol problems are conceptualized and how common beliefs about alcoholism may interfere with potential interventions. Practical strategies for screening and intervening in alcohol-related problems will be discussed. The lesson will show that rehabilitation professionals are in a good position to identify and provide brief interventions for clients with alcohol-related problems.

The Prevalence of Alcohol Problems Among Persons With TBI and SCI

Corrigan[2] reviewed the literature on alcohol and TBI and found that the prevalence of pre-injury alcohol abuse or dependence ranged from 16%–66%. The most rigorous studies and those conducted in rehabilitation settings produced the highest prevalence rates, between 44% and 66%. Persons with SCI also report greater than average preinjury alcohol consumption, and 35%–49% report a history of significant alcohol problems.[4]

Another indication of alcohol-related problems among people with TBI or SCI is alcohol intoxication (blood alcohol level greater than 100 mg/dL) at the time of injury. Among patients with TBI, Corrigan[2] found that rates of alcohol intoxication ranged from 36% to 51% among the seven studies he reviewed. Alcohol intoxication rates for SCI reported in the literature are 40%[5] and 36%.[6]

Longitudinal surveys of alcohol use and alcohol problems among persons with TBI and SCI show that drinking declines during the months immediately following injury, followed by increased drinking during the first and second years after injury.[5,7] Drinking problems after injury typically represent a continuation of preinjury problems, though there appears to be a small percentage of persons with TBI and SCI who develop alcohol problems for the first time following their injury.[8,9] Cross-sectional data suggest that alcohol consumption after TBI and SCI may be somewhat higher than in the general population.[10,11] However, rates of alcohol abuse may be particularly high among selected groups such as vocational rehabilitation patients,[12] those in post-acute rehabilitation programs,[13] and among veterans with SCI.[14]

Taken together, these studies provide considerable support for the idea that a history of alcohol problems is common among people who sustain an SCI or TBI. **Rates of lifetime alcohol abuse or dependence approach 50% while current dependence at the time of injury is nearly 25%, or 3 to 6 times higher than in the general population.** Males are at higher risk than females. Drinking declines soon after injury, but increases over time, probably as the person resumes greater independence. There is little known about who resumes drinking, why, or when. People in post-acute and vocational rehabilitation settings may have especially high rates of alcohol abuse, possibly because alcohol problems interfere with achievement of community integration goals and necessitate additional psychosocial services.

The Effect of Alcohol-Related Factors on Outcome

A preinjury pattern of chronic alcohol abuse or dependence is predictive of numerous negative outcomes after TBI and SCI. Preinjury alcohol abuse is associated with increased risk of mortality and more severe brain lesions.[2] **Patients with a history of alcohol abuse demonstrate poorer neuropsychological test performance one month and one year post injury.**[15] Those with a history of alcohol problems are at higher risk for emotional and behavioral problems, are less likely to successfully integrate back into the community, and are at higher risk for recurrent TBI.[2] Since many of these studies were not able to completely control for potential confounding factors, the precise role alcohol plays in poorer outcomes merits further study.[15] Persons with SCI who had comorbid alcohol problems were found to spend less time in productive activities such as rehabilitation therapies[16] and have higher rates of suicide.[17]

Studies of the effects of alcohol intoxication on neurological outcomes provide mixed results. Some studies have shown that alcohol intoxication at the time of TBI is associated with poorer short-term outcomes such as longer length of coma, a longer period of agitation,[2] and greater cognitive impairment one to two months post injury.[18] Other studies of persons with TBI have found no relationship between blood alcohol level and neurological outcome.[19] These conflicting data may derive from the fact that, on a physiological level, alcohol may have both neuroprotective and neurotoxic effects following acute TBI.[20] On the other hand, both animal[21] and human studies[6] suggest that alcohol intoxication may be associated with more severe SCI.

It is widely suspected that even moderate alcohol consumption after TBI may dampen neurological recovery and magnify cognitive impairments.[13] Yet there is surprisingly little empirical research in this area. Clearly, alcoholism can cause cognitive impairment, including permanent brain damage.[22] Cognitive impairment also can develop in heavy "social drinkers" and the effects are roughly dose-dependent.[23] There is speculation that, by interfering with the reestablishment of dendritic connections among surviving neurons, alcohol may inhibit neurological recovery.[2] The only study of brain functioning influenced by drinking after TBI found that event-related potentials are more impaired among persons with TBI who also abused alcohol compared with persons who only had a TBI or only abused alcohol.[24] Additional support for the idea that TBI magnifies the acute neurocognitive effects of alcohol comes from self-reports of increased sensitivity to alcohol[25] and the finding that alcohol intoxication and TBI produce similar neuropsychological impairments.[26]

Regarding persons with SCI, Krause[27] speculates that return to drinking may interfere with health maintenance behaviors secondary to impaired judgment, coordination, and memory. Curiously, people with preinjury alcohol problems who abstained from alcohol after injury have been found to have increased risk for developing pressure sores.[28]

The relevant literature suggests that alcohol intoxication at the time of injury is most likely to affect early indicators of cognitive function, but that with time and physical recovery the influence of intoxication on cognitive functioning diminishes. The effect of preinjury alcohol abuse on post-injury outcomes is the most well established finding. However, even this relationship remains controversial due to the potential confounding effects of numerous variables, including education level and preinjury socioeconomic status as well as post-injury drinking. Extremely little is known about the harm associated with alcohol use or abuse that occurs after TBI or SCI. The limited data, however, suggest that drinking may interfere with recovery and increase risk of reinjury.[29]

Historical Perspective on Alcoholism

Alcoholism can be conceptualized in categorical terms as a disease, or as a continuum of alcohol-related problems. The prevailing disease model is represented by the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM-IV)[30] definition of alcohol dependence. The disease model views alcoholics as qualitatively different from normal persons. That is, persons with alcoholism are thought to have a medical or psychological defect resulting in behaviors such as excessive consumption. **Disease-model alcoholism is believed to be progressive and can only be put in remission through abstinence.** Nonalcoholics are assumed to have no such defect and to experience no adverse consequences from alcohol.

Contemporary theory and research on alcoholism are moving away from the strict disease model toward a continuum model, which holds that alcohol-related problems occur along a spectrum of severity.[1] The movement away from conceptualizing alcoholism categorically as a disease follows an historical pattern similar to that of other medical conditions:

> The historical record also suggests that treatment for any problem tends to originate as a result of attention being drawn to severe cases. Initially, treatment consists of applying to these cases the existing remedies that are available when the problem is first recognized. As time passes, however, it becomes increasingly clear that (a) cases other than severe cases exist and (b) other methods can be used to deal with them . . . Thus, it is not surprising to find the same progression in the treatment of persons with alcohol problems.[31] (pg. 59, italics added).

The Institute of Medicine (IOM) report, "Broadening the Base of Treatment for Alcohol Problems,"[31] was an important milestone in progress away from a strict disease model. The IOM report explicitly adopted the terminology "alcohol problems" to look at the issue from a broad public health perspective. The IOM report emphasizes that prototypical alcoholics represent a minority of Americans with alcohol problems. A large proportion of Americans consumes hazardous amounts of alcohol and incurs significant harm from alcohol use without meeting criteria for alcohol dependence. It is estimated that persons with less severe alcohol problems outnumber people with severe alcoholism by a ratio of 4:1.[32] The DSM-IV also recognizes gradations of alcoholism other than dependence through the diagnosis of alcohol abuse.[30] The modal "alcoholic" whom rehabilitation professionals will encounter is someone with mild-to-moderate problems with alcohol.

Second, the IOM model emphasizes that there are no clear boundaries between normal use and abuse

of alcohol or between alcohol abuse and dependence. Consumption and problems seem to exist along a continuum. Therefore, it makes little sense to create the false dichotomy the word disease tends to imply. Third, rather than a universal downward course, consumption and the degree of alcohol-related problems vary significantly over the lifetime of the average person with alcoholism.[33] Moreover, the majority of changes that occur in drinking patterns and problems are probably not attributable to treatment.[34]

The Disease Model: Common Assumptions

In addition to these broad conceptual differences, there are other assumptions attributed to the disease model that deserve examination. These common assumptions appear to conflict with the contemporary literature on addictive behaviors and potentially interfere with innovations in clinical care.

First, there is the belief that clients must acknowledge that they have an alcohol problem before any intervention can begin. Research suggests that requiring a client to admit that he or she is an alcoholic is not only unnecessary for therapeutic change, but may actually generate resistance.[35] In contrast, a nonjudgmental attitude on the part of the therapist and avoiding labels are thought to facilitate greater motivation to change and more valid self-report.[35]

Next, there is the belief that not wanting professional help is a sign of "denial." Yet most people with addictive behaviors or other psychological problems do not seek professional help.[36] Our research has shown that, while most people with TBI or SCI and alcohol problems do not want treatment, most do want to change their use of alcohol.[4,37] The term "denial" unnecessarily pathologizes and blames the client for a condition that most people seem to have, minimizing their problems and preferring to change on their own.

Two corollary beliefs are that denial is a personality trait of alcoholics and that denial must be confronted. Numerous studies have failed to find differences between alcoholics and nonalcoholics on measures of denial.[35] Rather, denial has been shown to be an interpersonal phenomenon.[38] **Therapist behaviors seem to influence denial more than client personality traits. A consistent finding in the literature is that therapist confrontation increases client resistive behaviors, while empathic listening decreases resistance.[35]** Confrontational therapist behaviors are also associated with negative outcomes in the longer term. Higher levels of confrontational therapist behaviors predicted greater alcohol consumption among clients one year after treatment.[38]

Another widely held belief is that specialized treatment is always necessary to address alcohol problems. Instead, the research literature suggests there are many routes to recovery and that only a little help may go a long way among persons with milder alcohol problems. For example, a review of at least 44 controlled studies showed that brief interventions of one to three sessions produced significant change and were often as effective as more intensive treatment.[39] In fact, there is more evidence for the efficacy of brief interventions than any other substance abuse treatment modality.[40] People with mild alcohol problems also may benefit significantly from following a self-help guide.[41] Studies of persons with alcoholism show that the majority of those who recovered (77%) did so on their own, without treatment, professional help, or even Alcoholics Anonymous.[34]

Finally, there is the belief that lifetime abstinence is the only acceptable goal. There is little question that lifetime abstinence is the best option for many persons with alcohol problems. However, there are also good reasons to support moderate drinking when this is the person's clear preference. Having clients set their own treatment goals is thought to be more therapeutic than prescribing goals; requiring a commitment to abstinence at the outset may unnecessarily exclude individuals who could make other meaningful changes in their drinking.[42] Many clients who initially refuse abstinence will reconsider it after a trial of moderate drinking fails.[43]

In summary, common assumptions associated with the disease model may not be applicable to all persons with alcohol problems. The picture that emerges from the recent research literature is one in which alcohol-related problems are more treatable and have more in common with other psychological disorders. In fact, one way to improve how we address alcohol-related problems is to provide less intensive interventions to more people, and to do so in the context of the rehabilitation setting. The following section describes efficient ways to identify rehabilitation clients with alcohol problems and promote positive change in their drinking habits.

Screening for Alcohol Problems

A number of authors have argued that universal alcoholism screening is needed to address the underlying cause of nearly half of the traumatic injuries in the United States.[44] Systematic screening forms the foundation for any effective intervention. Without universal screening, alcohol problems are under-recognized and may undermine the rehabilitation process.[45] Screening can be conducted with little investment of time by clinical or nonclinical staff. However, federal law requires special protection for information related to alcohol and drug abuse and these data should not be released without appropriate informed consent.[46]

Some clinicians may be reluctant to institute alcohol screening and assessment procedures because they are doubtful that the results will be valid. Yet, reviews of the literature have concluded that persons with alcohol problems generally provide reliable and valid reports if proper measures and procedures are used.[47] To maximize the validity of self-reports, interviews should be conducted in clinical settings when the subject is alcohol free and given reassurances of confidentiality. Alcohol screening measures should be imbedded within the context of a larger battery of health-related assessments and emphasis should be placed on alcohol use as one of several behavioral risk factors that might have an impact on health or rehabilitation outcomes. Adjunctive biomedical data such as blood alcohol levels or liver function tests can enhance validity, partly as a "bogus pipeline." Any alcohol-related assessments should be conducted in a nonjudgmental fashion, avoiding terms such as "alcoholism" or similar labels.

There are a number of brief screening measures that have been found to be reliable and valid indicators of significant alcohol-related problems. One valid tool for identifying people with alcohol dependence is the CAGE questionnaire.[48] **The CAGE acronym stands for four questions:** Have you ever felt you should **CUT** down on your drinking? Have you ever felt **ANNOYED** by someone criticizing your drinking? Have you ever felt bad or **GUILTY** about your drinking? Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover **(EYE OPENER)**? Each affirmative response is scored one and a total score of two or greater is considered clinically significant. The CAGE has been used extensively in medical settings and requires less than one minute to administer. The CAGE has documented internal consistency and criterion-related validity with sensitivity and specificity ranging from 60%–95% and 40%–95%, respectively.[47] Simple questions about typical of quantity and frequency of alcohol use can complement the CAGE to distinguish people with current abuse or dependence from those who are in remission.

Another recommended measure is the Alcohol Use Disorders Identification Test (AUDIT). The AUDIT was developed by the World Health Organization to promote early identification of problem drinking in primary care medical settings.[49] The AUDIT consists of ten items: three questions on alcohol consumption, four questions on alcohol-related life problems, and three questions on alcohol dependence symptoms. A cut-off score of eight is recommended.[49] The AUDIT requires two minutes to administer and approximately 1 minute to score. Reported sensitivities have typically been above 90% with specificity in the 80%–90% range.[49]

Advice and Brief Interventions

Once persons with alcohol problems are identified, what can rehabilitation professionals reasonably do to influence drinking? In the previous sections it was emphasized that while for some people alcoholism is a chronic progressive condition requiring specialized treatment, for others, probably the majority of problem drinkers, change is possible. **Moreover, the research literature suggests that there is considerable hope that nonspecialists may have a significant impact on drinking behavior through advice, brief interventions, or by facilitating referrals to substance abuse specialists. Therefore, this last section contains strategies that counselors from a variety of backgrounds can learn to use with little time investment.** These strategies will not help every person, but if used systematically, will likely help a substantial proportion of persons with alcohol problems.

Advice:

Giving at-risk clients brief advice to abstain or reduce drinking is possible for any rehabilitation professional who works with these client populations. **Numerous controlled studies in medical settings have shown that brief physician advice results in significant, lasting decreases in drinking.[47] For example, a recent study showed that two 10–15 minute interactions with a primary care physician resulted in a 40% reduction in alcohol consumption among problem drinkers who were measured one year after treatment.[50]** Advice may be more effective when it is combined with self-help materials or personalized feedback and information about the adverse health effects of alcohol.[47] Several self-help guides are available,[51,52] including one written specifically for persons with TBI[53] An excellent resource for giving advice has been developed for primary care physicians and can be obtained from the National Institute on Alcohol Abuse and Alcoholism (http//silk.nih.gov/silk/niaaa1/publication/physician.htm).

Effective advice begins with broaching the subject of alcohol and screening for excessive alcohol consumption and alcohol-related problems as described above. The next step is to convey concern based on what is considered sensible or normal drinking. For example, "You are reporting drinking that is more than normal social drinking. Normal social drinking for men is considered to be no more than 2 drinks per day or a maximum of 14 drinks per week (for women, 1 and 7 drinks, respectively)." Inform the client of the health risks associated with drinking that exceeds this amount, such as increased probability of liver disease, cardiovascular disease such as stroke, cognitive impairment, pancreatic disease, and accidental injuries. Clearly recommend a menu of change options: "I recommend to all my clients who drink more than normal that they either abstain, cut down, or seek treatment." For clients who report symptoms of dependence such as tolerance, compulsion to drink, inability to stop, or drinking to avoid withdrawal, you may want to recommend only abstinence or treatment. Decide on a plan and monitor progress. Ask the client if he or she is ready to make any of these changes. If the client is ready, formulate a concrete plan of action. Attempt to make any treatment referrals before the client leaves. Agree to monitor progress on this issue along with any other plans being made. If the client is not ready, ask if he or she would be willing to seek more information, for example by seeing a specialist for a more detailed assessment of drinking.

Brief Interventions:

Brief interventions are for the clinician who has more time and interest in promoting change in alcohol use. Brief interventions have been used in a variety of settings, both as a stand-alone treatment and a means of enhancing the effects of subsequent treatment[54] Brief interventions typically last anywhere from one to four sessions. **The most widely known model of brief interventions is motivational interviewing.[35] Motivational interviewing relies heavily on Rogerian principles of empathic listening, unconditional positive regard and belief in the inherent power of persons to change.[35]** The therapist primarily uses open-ended questions followed by various forms of reflective listening and summaries designed to elicit reasons to change from the client. While the therapist avoids confronting the client, the goal of therapy is for the client to realize, on his or her own, that excessive drinking and associated problems are not consistent with their core values and aspirations. Detailed training manuals[35,55] and workshops (see www.motivationalinterviewing.org) are available for clinicians to learn motivational interviewing. Motivational interviewing strategies have been adapted to use with a wide range of clients in a number of different settings[35,56] including persons with brain injury.[57] The Ohio Valley Center for Brain Injury Prevention and Rehabilitation (www.ohiovalley.org) has published education and training materials specifically for persons who want to use motivational interviewing strategies to help clients with TBI. A recent randomized controlled study conducted with hospitalized trauma patients showed that a single motivational interviewing session resulted in almost a 50% reduction in drinking and a 50% reduction in readmissions for trauma one year after initial treatment.[58]

The effective elements of brief interventions have been summarized by the acronym FRAMES (See

Table 1).[39] **These key elements are *Feedback, Responsibility, Advice, Menu of options, Empathy and Self-efficacy*.** Typically, based on results of an assessment, the client is provided with personally relevant feedback that includes the impairment or risks associated with past and future drinking. The therapist emphasizes the client's personal responsibility for change, provides clear advice to make a change in drinking, and gives a menu of alternative strategies for changing problem drinking. This information is provided with empathy and understanding, not confrontation, to reinforce the client's hope, self-efficacy, or optimism.

Motivational interviewing dovetails with recent research on client stages of change. The transtheoretical stages of change model is an empirically based model that characterizes motivation to change as a spiral continuum from precontemplation (not considering change), through contemplation (ambivalent about change), determination (getting ready for change), action (making behavioral changes), and maintenance (see Table 2).[36] The model postulates that client stage of change can help predict outcomes and that matching therapist strategies to the client's stage of change can improve outcomes (see Table 3).

For example, the therapeutic goal for precontemplators is to raise their awareness, not challenge them to change. The motivational interviewing therapist is trained to use open-ended questions, reflective listening, and affirmations in response to resistance; to provide personally relevant information; and to subtly raise doubts in the client's mind about whether he or she is truly satisfied with the current pattern of alcohol use. Research suggests that moving a client from precontemplation into contemplation increases by 50% the chance of changing behavior over the next year.[36]

Table 1
EFFECTIVE INGREDIENTS OF BRIEF INTERVENTIONS (FRAMES)

Feedback
- Structured assessment of the personal costs and benefits of changing or not changing
- Ask about the "good things" then the "less good things"

Responsibility
- "It's up to you, no one can change for you"
- Implicitly empowers the client

Advice
- Ask permission to give advice
- Suggest some behavior change

Menu
- Giving clients choice enhances commitment
- Offer alternative goals (e.g., stop, cut down, or no change)
- Offer alternative strategies (e.g., treatment, AA, self-change)

Empathy
- Clarify and amplify the client's experience
- Avoid imposing your own views

Self-efficacy
- Reinforce hope and optimism about the client's ability to change
- Reframe past failures as successive approximations of the goal

(adapted from Miller and Rollnick, 1991)[35]

The therapist helps contemplators resolve ambivalence by exploring the pros and cons of their alcohol use, eliciting reasons for change, and highlighting discrepancies between life goals and the consequences of drinking. The therapist avoids taking sides, but rather helps these individuals weigh reasons for changing against reasons for not changing. On the other hand, when patients are in the action phase, the motivational interviewing therapist activity can be directed at consolidating reasons for change, selecting among various change strategies, devising a detailed change plan, and building on the patient's prior change attempts. For persons in the maintenance phase, interventions can focus on helping prevent or minimize the effects of relapse.

Facilitating Referrals

In many cases the rehabilitation professional may decide to focus on simply referring at-risk persons to outside specialists, whether it is for formal treatment, further evaluation, or perhaps to attend Alcoholics Anonymous meetings. However, convincing clients to follow through with a referral is no easy endeavor. Traditionally, adherence to referrals has been quite poor, around 10%–14% in some studies.[47] Fortunately, a science is developing around how to improve adherence to referrals.[47] To improve referrals, counselors can use many of the same strategies described under giving advice and brief interventions. The overarching goal is to collaborate with the client as an equal partner in the process of exploring options and making decisions.

To begin with, the counselor can summarize the potential risks (e.g., health, recovery, rehabilitation funding) that may be associated with ongoing at-risk drinking. Feedback should be conveyed in a supportive, nonjudgmental manner, avoiding using terms such as "alcoholic" or "alcoholism." Adopt the neutrality of a consultant by stating that (e.g., "The data suggest . . ." or "People with your pattern of results typically . . .") Next, check with the client regarding understanding and opinions about the feedback. Attempt to find common ground and agreement before considering advice. Questions such as "What concerns you most about these data?" can help identify key reasons for change. Ask for permission before offering advice and reemphasize the client's freedom of choice (e.g., "No one can make you change or do it for you.). Whatever you do is up to you." Normalize ambivalence and uncertainty. Offer the client more than one option and include not changing as one possible choice. Have prepared concrete ways of responding to common choices, such as the phone numbers of intake workers in some local treatment programs (see SAMHSA web page treatment center locator; www.samhsa.gov), booklets on the place and time of local AA, Rational Recovery, or Moderation Management meetings, web addresses of alcohol self-help groups (e.g., www.moderation.org), and handouts on how to try to change drinking on one's own (see NIAAA web page www.niaaa.nih.gov). If possible, help clients take action, for example by making phone calls to establish direct contact with referral sources and set up appointments. Helping people seek help is not "enabling." If the client chooses no change or if resistance increases around trying to make a referral, reflect their ambivalence, demonstrate respect for the choice of doing nothing for now, and ask for permission to bring up the subject at a later date. Some clients respond to the idea of self-monitoring their drinking for a while and perhaps defining what they think is a "safe" drinking range that they should not exceed. Subsequently, if they exceed this level the counselor has an opportunity to revisit the question of whether any other change is indicated.

In referring clients for specialized substance abuse treatment, the question arises, "What treatments or treatment programs are best for people with disabilities?" Unfortunately, the demand for substance abuse treatment in the United States far exceeds the supply. Moreover, there is frequently little reliable information available on a given treatment program and less on the ability of programs effectively to serve people with disabilities. Initially, referrals may need to be made almost without guidance. Later, the counselor will get feed-

Table 2
TRANSTHEORETICAL STAGES OF CHANGE

Precontemplation
- Unaware or underaware of problems and not considering change
- More surprised than defensive

Contemplation
- Some awareness of problem
- Ambivalent, weigh pros/cons of change

Determination
- Thoughts and feelings reflect readiness, but do not guarantee actions will be made
- Action likely to be made within a few months

Action
- Does something to initiate change
- First behavioral signs of change

Maintenance
- Actions to sustain change are needed
- May require strategies that are different from initiation of change

Relapse
- Avoid imposing your own views
- Resumption of problem behavior is normal, but may trigger demoralization
- Preparing for relapse is helpful

(adapted from Prochaska, DiClemente & Norcross, 1992)[36]

back from clients about which programs are most effective and accommodating.

Many believe that AA is not effective for persons with TBI.[13] However, it can be difficult to find treatment programs in the community that offer something else,[59] and AA, used in conjunction with professional counseling, does seem to be effective.[60] **Whenever clients are interested in using AA, it seems prudent to encourage this type of self-help in conjunction with professional counseling.** To this end, the National Head Injury Foundation[13] rewrote the 12 steps in more concrete terms and produced a model educational letter to introduce AA sponsors to the special issues among persons with alcoholism and TBI.[13]

Since many programs rely heavily on group-based psychoeducational treatment, some thought should be given to the question of whether the client has the cognitive capabilities to learn in that environment. It may be useful to adopt an advocacy role and help the client request specific accommodations such as less group-based treatment, more individual counseling, written information to reinforce key points, and help clarifying some of the more abstract concepts.

Table 3
SELECTED STAGE-BASED THERAPEUTIC STRATEGIES

Precontemplators

- Give feedback in matter-of-fact manner
- Reflect, even exaggerate resistive statements
- Emphasize the client's personal responsibility and freedom of choice
- Clarify the consequences of the client's behavior in a nonjudgmental manner
- Avoid argumentation; when you begin to argue, change strategies or discontinue
- When resistance is generated, cut losses and revisit the issues at another time

Contemplators

- Elicit the client's primary incentives for change
- Have the client reflect on the good things and less good things about his or her behavior
- Don't take sides; instead, reflect
- Give advice tentatively, (e.g., ask for the client's permission first)
- Give menu of options, have the client choose from possible goals and strategies
- Emphasize the client's responsibility and freedom
- Boost self-efficacy (e.g., by reframing past failures as successive approximations)

(adapted from Miller Rollnick, 1992)[55]

Case Example:

The alcohol screen (AUDIT) was imbedded into a larger battery of tests. Emphasize client's control and responsibility at the outset. *The italicized type is a sample of counselor notations.*

The alcohol screen (AUDIT) was imbedded into a larger battery of tests. Emphasize client's control and responsibility at the outset.

***Counselor**: So, Mr. Smith—thanks for completing the questionnaires I gave you last week. I want to talk with you about the results over the next couple of times we meet. (Discuss one or more other topics first) . . . Next, I want to give you feedback from your answers to the questions about alcohol. As I told you before, it is my job to give you feedback about your answers. It is your job to decide if you have any concerns or want to make changes. I won't tell you what to do.*

***Client**: Yeah, I thought you were going to bring this up—what does this have to do with getting back to work, anyway?*

The client is pretty defensive, probably in precontemplation, I'd better go slow and "roll with resistance." The most I could do today is to have him entertain the idea alcohol may be harming him. I can use reflection that exaggerates his point a little.

***Counselor:** So it really doesn't make any sense to talk about alcohol when you are here to get back to work.*

***Client:** Well, if I were an alcoholic it would make sense, but I'm no alcoholic.*

The client is concerned about labels; I'd better validate his concerns.

Counselor: *You are saying that if you had big problems with alcohol it would make sense to discuss it, but not unless there were major problems.*

Client: *Right.*

Side with the client's impression that he has no problems and focus on the data.

Counselor: *So this might go pretty quickly. If you don't have any concerns about your drinking after we review your answers, we can just move on.*

Client: *Okay.*

Counselor: *Let's look at your answers then. . .*

Focus on the positive, on the absence of pathology, to build trust and minimize the likelihood that the client's prediction that you will blame and label him.

Counselor: *On the first measure, you reported you drink only about 2–3 times per week, clearly not every day, or not even most days.*

Client: *Right . . . mostly weekends, Friday and Saturday nights.*

Counselor: *It also looks like you never have trouble stopping drinking and are actually very responsible about your alcohol use. I mean that you have never failed to do what was expected of you because of your drinking.*

Client: *Right, I am a darned good worker. My drinking has never stopped me from putting in a good day's work. I show up even when I am feeling pretty rough from the night before.*

Pass up the inclination to point out that the client admitted getting drunk. Summarize all the good points.

Counselor: *So you drink only a few times per week, you can stop when you want to, you never drink in the morning, and alcohol has never gotten in the way of doing a good job at work. Does that seem about right to you?*

Client: *Yeah.*

Giving additional feedback

Counselor: *Now you said that when you do drink you have about 5–6 drinks.*

Client: *Right.*

Counselor: *That would mean you typically have somewhere between 10–18 drinks per week, a bit more than 50% of American males who consume about 4 drinks per week or less. How does that fit with your impression?*

Client: *All right, I guess.*

Counselor: You also said that at some point someone was concerned about your drinking or suggested you stop or cut down.

Client: *Oh, that doctor who took care of me after the car crash said he didn't want me to drink, but I tried drinking again after a while and it didn't seem to hurt anything.*

Counselor: *So nothing disastrous has happened. What was your doctor concerned about, anyway?*

Client: *Something to do with my head injury, I guess.*

I'd better reflect back the client's unconcern and find out what he knows before giving information.

Counselor: *It sounds like you are not really that concerned about how alcohol use could affect your brain injury recovery. Tell me what you know about how alcohol can affect your recovery.*

Client: *Nothing, I guess—I just thought something really bad would happen and it never did.*

Ask permission before giving information.

Counselor: *Remember, I am not going to tell you what to do, but do you want any information about how alcohol can affect recovery from brain injury?*

Client: *Sure, I guess . . .*

(see Appendix 1 for information on alcohol and brain injury) Explain in matter-of-fact terms.

Use impersonal language such as "Research suggests that brain injury recovery can continue for more than two years and that people can improve their chances of maximal recovery by abstaining from alcohol . . ."

Counselor: *What do you think about what I said?*

Client: *I didn't know alcohol could hurt my recovery. But I feel fine and still haven't had anything bad happen.*

End with a balanced summary. Don't ask, "What do you want to do?" This assumes that the client wants to make some sort of behavioral change. Reflect, reflect, and summarize. Reemphasize the client's control and tie back to his key values.

Counselor: *So, on one hand, you can control your drinking and you have not noticed anything terrible happening as a result of drinking since your brain injury. On the other hand, you drink a bit more than average, still have potential for more brain injury recovery, and you acknowledge the possibility that drinking could affect recovery. It's really up to you to decide if drinking is important enough to risk having less recovery. That comes down to a person's values. No one can make that decision for you . . . Where does this leave you?*

Client: *I'm not sure.*

End the discussion before the client feels pressured to change now and gets defensive. He's at least contemplating the possibility his drinking may not be 100% safe. Reinforce any positive expressions of concern he has made.

Counselor: *Well, you have been very open-minded today, listening to feedback and information. You seem content with your drinking now, with no real reasons to change. Should we move on to another subject and talk about this more the next time we meet?*

Client: *Okay.*

Conclusion

One way to provide better alcohol-related services for persons with disabilities is by improving access to effective treatment. Rehabilitation professionals can promote access to treatment by bringing empirically based alcohol screening and brief interventions into the medical, vocational, rehabilitation and independent living settings in which people with disabilities are usually seen. Rehabilitation professionals can take several practical and relatively brief steps to promote better outcomes in the area of substance abuse. We can raise awareness of the issue by advocating for universal screening for alcohol problems in our rehabilitation programs. We can become more familiar with current thinking in the area of addictive behavior and help dispel myths among our colleagues regarding these problems. We can learn brief counseling techniques designed to facilitate self-change or improve the probability of successful referral into treatment. By taking these steps we can help make treatment of substance abuse problems a routine part of comprehensive rehabilitation services.

References

Appendix 1

ALCOHOL AFTER TRAUMATIC BRAIN INJURY

Alcohol and brain injury recovery

- Recovery from brain injury continues for at least 1–2 years after injury.
- Alcohol seems to slow or stop brain injury recovery, possibly by interfering with neurons making new connections with each other.
- Not drinking is one way to give the brain the best chance to heal.

Alcohol, brain injury, and seizures

- Traumatic brain injury puts survivors at risk for developing seizures (epilepsy).
- Alcohol lowers the seizure threshold and may trigger seizures.
- Not drinking can reduce the risk of developing post-traumatic seizures.

Alcohol and the risk of having another brain injury

- After one brain injury, survivors are at higher risk (3 to 8 times higher) of having another brain injury.
- Drinking alcohol puts survivors at even higher risk for having a second brain injury.
- Not drinking can reduce the risk of having another brain injury.

Alcohol and mental functioning

- Alcohol and brain injury have similar effects on memory, mental speed, balance and thinking.
- Alcohol seems to magnify the negative effects of brain injury.
- Alcohol may affect brain injury survivors more than it did before the injury.
- The negative mental effects of alcohol can last from days to weeks after drinking stops.
- Not drinking is one way to maximize your mental abilities.

Alcohol and sex

- Alcohol reduces testosterone production in males.
- Alcohol reduces sexual desire in men and women.
- Alcohol reduces sexual performance in men (erection and ejaculation).
- Alcohol reduces sexual satisfaction in men and women.
- Abstinence from alcohol improves sexual ability and sexual activity in men and women.

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Questions Based On This Lesson

To earn CE credits, answer the following questions on your quiz response form.

5. The rate of lifetime alcohol abuse or dependence among persons with TBI or SCI is about:

A. 10%

B. 25%

C. 50%

D. 75%

6. In order to reduce clients denial and resistance about their alcohol problems, the counselor should:

A. Confront the client with the facts of their drinking problems.

B. Use empathic listening.

C. Advise the client to attend AA.

D. Work on having the client accept that they are an alcoholic.

7. Which of the following is an acronym for an alcohol screening measure?

A. FRAMES

B. DRINK

C. AUDIT

D. SMASHED

8. All of the following statements about advice and brief interventions are correct, *except*:

A. They are never as effective as longer forms of treatment.

B. People who are not alcoholism specialists can learn to use them.

C. They can influence drinking one year after the intervention.

D. They can be tailored to the client's stage of change.

Directions in Rehabilitation Counseling

Volume 12 Lesson 3

Recent Developments in Genetic Testing and the Rehabilitation Counselor

Joseph E. Havranek, EdD, CRC

Dr. Havranek is an Associate Professor of Rehabilitation Counseling, Bowling Green State University at Bowling Green, OH.

Introduction

Rehabilitation counseling services have expanded beyond the traditional issues of employment for adults with disabilities to include the needs and concerns of pediatric and geriatric populations. **As a result, genetic counseling has become even more important to the rehabilitation counselor because of the various roles a rehabilitation counselor may have to fill as an educator, member of a support network, advocate, and technical advisor.** This lesson will review genetic issues, including genetic testing and genetic discrimination, then apply those issues to rehabilitation counseling practice. Genetic testing technologies may soon be both cost-effective and available for a wide range of hereditary diseases. In many countries, screening for hereditary disease is promoted as a cost-effective way to identify individuals who are at risk for such diseases. This allows health services to be targeted toward individuals who are most likely to benefit from early intervention.[1] Due to the dramatic impact of increased knowledge of hereditary diseases, identification of genetic processes, and development of DNA-based diagnostic tests during the past 20 years, programs for genetic screening and counseling have become widespread.[2]

The scope of genetically-based disorders can be appreciated when one considers the following: (1) approximately 4000 inherited genetic disorders have been identified and affect 1%–3% of pregnancies; (2) due to medical advances in the treatment and prevention of other diseases, about 40% of childhood mortality and 5%–10% of all pediatric hospital admissions are due to genetic disorders; and (3) advances in diagnostic measures are dramatically expanding the potential for genetic screening and prenatal diagnosis.[3,4] Pembrey [3] contains an excellent and insightful overview of the genetic process.

The Human Genome Initiative (HGI) is the result of new diagnostic procedures and treatments for genetically-based disorders. The human genome is the collection of human chromosomes in which all human genes are found.[5] **The HGI began in 1988 and is funded by the National Institutes of Health and the Department of Energy. Project goals include identifying all of the more than 100,000 genes in human DNA, determining the sequence of the more than three billion chemical base parts that make up human DNA, storing this information in databases, developing tools to analyze this data, and addressing the ethical, legal and social issues that may arise from this project.**[5]

It should be noted that some people are concerned about the potentially negative social consequences of genetic profiling and oppose HGI. They fear that the resulting information will be used to discriminate against people with undesirable genetic backgrounds and deprive people of their civil liberties, especially in the areas of insurance and employment.[6] These concerns are partially being addressed by putting in place certain restraints programmatic on biomedical and clinical research, which may result in some valuable subject areas not being explored.[7,8,4] **Among these restraints are safeguarding the privacy of individuals and groups; limiting potential misuses of genetic data in workplaces, schools and courtroom; and mediating the impact of genetic research on the concepts of humanity and personal responsibility.**

Gostin[5] has noted that the benefits of HGI on genetic research include greater coordination, funding, and targeting of research, which may greatly accelerate the completion of the genetic map. The number of chromosomal markers identified will be so large that the time required for a research group to locate a specific gene will be reduced many-fold. The diagnosis of a number of diseases has already been affected by recent advances in genetic testing. These include cystic fibrosis, sickle cell disease, the thalassemias, Fragile-X syndrome, Duchenne's muscular dystrophy, hemophilia, Huntington's disease, retinoplasty, neurofibromatosis, and adult polycystic kidney disease.[9,5,3] The identification of the gene structures involved in each of these and other diseases, and the new technologies involved in this research, may lead to the development of effective therapeutic and prophylactic measures while simultaneously aiding in the discovery of new analytic and technological tools. These new technologies will also find myriad applications in industry.[9]

Genetic Counseling

Genetic counseling has been defined as "a communication process which deals with the human problems associated with the occurrence, or the risk of occurrence, of a genetic disorder in a family." [7, p. 27] The goals of genetic counseling include the following:[4]

- **Helping clients understand the medical facts regarding the disorder, including its diagnosis, probable cause, and avenues of management.**
- **Determining the contribution of heredity to the development of the disorder and risks for other family members.**
- **Choosing and implementing the most appropriate course(s) of action in light of risks, resources, and family goals.**
- **Making the best possible adjustments to a disorder in an affected family membe**
- **Reducing the risk of recurrence .**

Thus, genetic counseling addresses human problems associated with a genetic disorder, not just the disorder itself. Therefore, the goals of genetic counseling can be summarized as helping the client learn, understand, choose appropriate courses of action, and cope[4] with unexpected circumstances.[10]

Genetic counseling is most often provided by physicians who specialize in genetic disorders (i.e., medical geneticists) or by counselors who have an academic background in genetics (including rehabilitation counselors in programs accredited to provide comprehensive assessment and referral evaluation [CORE] training), as well as genetic counselors.[4]

The enormous increase in knowledge of the human genome and the potential for intervention in genetic disorders has had a variety of effects. For example, it has inspired some to construct a family history, which may reveal potential risks and allow

the parents to make an informed choice about conceiving. It has resulted in others being able to identify the presence of a genetic disorder and, after learning about the effects of that disorder, being faced with the painful decision of aborting the affected fetus or carrying it to term.[11] Genetic testing has also resulted in a number of challenges for the individual contemplating reproduction, including deciding whether or when to procreate, and with whom and by what means; the legal, social and governmental contexts in which reproductive freedom does or does not take place; how many children to have; what characteristics to choose for one's children (sex, size, health status); and whether to proceed with a high-risk pregnancy. The sharing of control and responsibility between the individual and society will also be a focus; as Brock stated **"The more difficult issue is the extent to which the broader society can legitimately claim a role in such decisions."** [11, p.46]

Many primary care physicians use the basic information developed in case histories to create a family genogram to identify potential risks.[12] This process is reinforced by the recent development of cost-effective genetic testing technologies. Currently, genetic testing is carried out in primary care settings only under the following circumstances: when there is an obvious underlying disease; when the family histories demonstrate a potential for rare conditions with grave morbidity and/or mortality; and as part of a limited screening process in prenatal and obstetric care.

Such screening may alter the routine practice of primary care physicians, who must follow formal policies and procedures to ensure the secure handling of genetics testing records. McCrary & Allen[12] have recommended the following office practices: (1) educating the office staff about the nature of such testing; (2) limiting the number or type of staff members who have access to genetic test results (including access to computer records); (3) segregating genetic test results from other medical records, if feasible; and (4) personally verifying the patient's written permission to release information regarding genetic test results.

Although primary care practitioners and prenatal care specialists will soon have access to the screening devices to assess the risk for some genetic diseases, they currently face a shortage of counselors trained to address genetic issues. Thus, it is reasonable to expect physicians, or even the clients themselves, to seek the advice of rehabilitationists. To ensure their ability to provide general counseling, as well as to know when to refer a client to a genetics counselor, rehabilitationists must become familiar with genetic counseling techniques and risk assessment strategies.

Genetic Testing: Purposes and Procedures

The overall purpose of genetic testing is to facilitate informed decision making about reproduction. According to Pembrey the objectives of prenatal testing are to give potential parents information to make the best choices for themselves. The goals of prenatal testing can be summarized as follows:[3]

- **It allows the widest possible range of informed choice to women and their partners at risk of having a child with a genetic disorder**
- **It reassures clients and reduce the level of anxiety associated with reproduction**
- **It allows couples at risk to start a family, knowing that (if they wish) they may avoid the birth of seriously affected children through the termination of an affected pregnancy**
- **It prepares a couple that wishes to know in advance whether their child is affected for any possible outcome (should they decided to continue the pregnancy) and to make sure appropriate treatment begins as soon as possible.**

Most of the general public and members of at-risk groups express very favorable attitudes toward and interest in being tested; however, their expressed interest does not necessarily translate into the utilization of services.[2]

Amniocentesis is currently the primary means of prenatal screening. Indications for undergoing amniocentesis include a maternal age greater than 35 years; a family history of a genetic disorder or inborn biochemical disorder; membership in a high-risk population; one parent being a known carrier of a genetic disorder; and abnormal levels of maternal serum alpha fetoprotein, which indicates an increased risk for a chromosomal or neural tube disorder.[2] It should be noted that concerns regarding amniocentesis are based on both the results of testing and the stress-provoking effect of the procedure itself.[2] Additional genetic tests include DNA analysis for mothers who are known carriers of a genetic disorder. A pre-implantation diagnosis can be made using in vitro DNA testing of fertilized embryos; after testing, only those embryos that are free of known genetic disorders are reimplanted. This procedure can be used when abortion is not an option. However, it costs $8,000 or more and is only available at a few genetic testing centers in the United States.[10]

Recent advances in prenatal testing, which can be used to identify individuals in an at-risk population who have a genetic disorder, may resolve problems of uncertainty for potential parents. Variables associated with the decision to use prenatal diagnostic procedures include willingness to abort, family approval of abortion, no foreseeable fetal viability, the need to reduce uncertainty, perceived severity of the disorder, previous experience with a child possessing a genetic disorder, the woman's age, precounseling reproductive plans, the desire to have children, and the level of genetic risk.[13] However, test results may also cause ethical and personal dilemmas[4] which are often based on the potential severity of the genetic disorder. These dilemmas may be mitigated by genetic counseling; however, the counselor must keep in mind the wide variation in severity of genetic disorders and that the severity of a given disorder can vary and severity is, at least in part, a product of each individual's perspective.[4]

Prenatal diagnosis can only be understood within the context of the emotional state of the prospective parents, which is influenced by stress, ambivalence, changes in self and body images, emotional instability, and changes in thinking processes.[4] The counselor must help the client understand that although research has shown that significant increases in short-term psychological distress frequently occur in light of such diagnoses and decision-making dilemmas, there is little evidence that the diagnosis and decision-making process increases distress over the long term (i.e., 6 months after testing).[4]

Counseling Issues

A primary challenge to the justification of genetic counseling is the lack of evidence that the provision of prenatal genetic information significantly influences parental behavior.[2,4] **Indeed, most studies conclude that genetic counseling does not result in dramatic changes in reproductive behavior and that the precounseling intentions of the parents comprise the best predictor of postcounseling reproductive decisions.[4] Moreover, when faced with a medical decision, many clients prefer to relinquish decision-making control to a professional.[13] Such a preference can be viewed as an exercise in self-determination rather than giving up control, particularly if the client has sufficient information and the capacity to make such decisions.**

Four therapeutic topics of special importance for clients were identified by Kessler:[14] pursuing hope, acquiring information, constructing meaning, and acquiring new coping skills. Conversely, psychological themes in genetic testing include the observation that risk information produces greater distress among individuals who were previously unaware of their risk status, the desire to reduce uncertainty, and goal conflict (i.e., their wish to receive good news).[2] Indeed, a 1995 genetic counseling follow-up study reported that after genetic counseling, clients perceived increased personal control, which resulted in more problem-focused and less emotion-focused coping styles.[15]

One of the main purposes of genetic counseling is to help clients select from among available options. Rational decision-making models are inappropriate and/or insufficient for clients facing these issues.[4] These families need help in terms of identifying and using genetic services, obtaining appropriate counseling, and gaining support to come to terms with making a decision that is right for them.[3] Decisions in genetic counseling are based on two different issues:[4] (1) whether to seek a prenatal diagnosis, and (2) how to use the information gained through a prenatal diagnosis (i.e., whether to continue a pregnancy with an affected fetus). A decision to seek information is not a decision to terminate pregnancy, even if such information reveals a genetic disorder. It is critically important that the counselor identify the decision making process in the family. Counselors generally favor providing clients with a clear and balanced presentation of issues and information, which allows the client to decide; however, many clients do not welcome this approach.[13] In one study, 42% of the clients wanted to know what the counselor thought was the right decision.[4]

Common misperceptions of genetic disorders include that they are all permanent, irreversible, or chronic; family linked, stigmatizing, and capable of evoking strong unpleasant emotions (e.g., fear, pity, and guilt for passing on a genetic disorder).[4] Therefore, prior to testing, genetic counselors must identify ways in which newly acquired genetic information will affect the lives of clients—psychologically, socially, and economically. Constructive results from genetic counseling may lead to changes in self-image, psychological status, and social stigmatization.[2] Given that birth defects are increasingly seen as avoidable,[4] the prospects for successful counseling is enhanced.

When test results show that the fetus is abnormal, the possibility of choosing an abortion must be addressed. This can be an especially difficult decision and one that is hard to cope with, especially over the short term. This issue must be examined carefully in light of the cultural and spiritual values of the family.[4]

Genetic Discrimination

As the ability to test for and detect genetic disorders increases, so does the potential for discrimination. **Gostin[5] has noted that prejudice, alienation, and exclusion often accompany genetic disorders, even though the conditions are neither the result of willful behavior nor subject to the client's control. It must be emphasized that testing for a genetic marker does not establish the onset date, nature, severity, course of the disease, or efficacy of treatment.[5] Additionally, the reliability and predictability of genetic tests are limited by the extent of knowledge about genetic disorders.**

Early in the process of identifying and dealing with genetic knowledge, activities were primarily aimed at improving the gene pool in order to increase what were perceived as positive characteristics and decease negative genetic material. This practice was evident in the late 19th and early 20th centuries. It was manifest in Germany, where the term eugenics originated.

Eugenics was defined by Galton as:

> **The science of improving the stock, which is by no means confined to questions of judicious mating, but which especially in the case of man, takes cognizance of all the influences that tend in however remote a degree to give the more suitable races or strains of blood a better chance of prevailing speedily over the less suitable than they otherwise would have had.**[16 p. 24–25]

An interest in eugenics was also evident in the United States, where, by 1937, 32 states had passed sterilization laws aimed at those with disabilities, especially mental retardation.[8]

Reported cases of genetic discrimination have generally not been about real cost or safety concerns; rather, they related to misconceptions and mythologies about disabilities.[5] These, in turn, are affected by the individual's cultural heritage and degree of acculturation. For example, in traditional Chinese culture a defect may be perceived as the result of a detrimental act by a relative, performed perhaps years before the child's birth.[17] Information about hereditary diseases can be highly beneficial for clients, especially information regarding prevention, diet, treatment, lifestyle, and reproductive changes.[5] Likewise, attitudes that foster genetic discrimination (whether based on misconceptions or perceived extent of disability) are harmful to individuals, public programs, and society; ultimately, they discount the potential contributions of a significant segment of the work force.

The current American legal system protects individuals with disabilities at three levels: (1) the federal Americans with Disabilities Act of 1990 (ADA)[18] and other federal disability rights legislation; (2) state laws outlawing discrimination; and, (3) local ordinances that further reinforce federal and state initiatives. The ADA protects not only individuals with disabilities, but also those perceived to have a disability. The ADA protects those who may be subject to discrimination based on their own, or their potential offspring's, genetic composition.[5] It also protects job applicants from medical inquiries made by a prospective employer before a job offer is made. Pre-employment inquiries can only be made as they relate to ability of the applicant to perform the essential functions of a specific job. Inquiries regarding an individual's genetic history are illegal.In addition, the Civil Rights Act of 1964 (Title VII)[19] bars discrimination based on race and gender, an important issue because genetic testing often disproportionately impacts vulnerable classes.[5]

Research to date has shown that very few employers are using genetic information in any area.[8] However, market research has revealed genetic testing in the U.S. is a burgeoning business with annual sales expected to be several hundred million dollars in the year 2000.[5] As more effective, cost-effective, and efficient means of testing are developed, the potential for abuse will grow. With increasing costs of health, life and disability-related insurance, employers and insurers could use screening devices to exclude those with potential for having an expensive claim. Gostin has also pointed out that genomic information could become available to employers, insurers, educators, police, and others who might not have the skill to understand or correctly serve individuals with a propensity to disability (whether perceived or actual).[5] Thus, issues that should be determined before undergoing testing include the following: whether tests results will be available to other parties, particularly potential or current employers and insurance agencies; the status of testing results with respect to health, life, and disability coverage, i.e., whether genetic disorders would exempt an applicant from coverage as a pre-existing disorder; and whether insurers will scale back all benefits for certain conditions, including genetically-based disorders.[12] The ADA will prevent insurers from using insurance underwriting techniques as a screen for discriminatory purposes. Gostin stated the potential ills that might be derived from genetic screening in this way:

> **By excluding qualified individuals from education, employment, government service or insurance, the marketplace is robbed of skills, energy and imagination...If fear of discrimination deters people from genetic diagnosis and prognosis, renders them less willing to confide in physicians and genetic counselors, and makes them more concerned with loss of a job or insurance than with care and treatment, the benefits of genetic data collection will not be fully achieved.**[5 p. 112-113]

Individual Counseling Procedures

Early diagnosis, whether by amniocentesis or other tests, enables individuals to seek genetic counseling and thus make informed decisions about possible courses of action.[20] In helping families come to informed decisions, the options of prenatal diagnosis, pre-implantation diagnosis, adoption, and egg and sperm donor programs should be reviewed. Counseling can aid couples in coping with decisions and come to a solution that is right for them.[3] However, couples are not the only parties who may be affected; the needs and desires of children, siblings, and parents must also be considered.[2,10]

The identification of a genetic disorder can cause a variety of reactions, including the following:

- **Shock, denial, grief, guilt, anger, disappointment, low self-esteem, and disruption of family dynamics and marital relationships.** [10]
- **Potential mother's feelings of external pressure to undergo an abortion.**[4]
- **Bonding to the pregnancy in hopes that it will turn out without complications.**[10]
- **Increased difficulty in decision-making.**[13]

Additionally, for women who present with emotional or neurocognitive deficits, issues of shyness, social anxiety, paranoia, and mood lability need to be assessed. Appreciating a client's prior knowledge, experiences, personal attitudes, expectations, apprehensions, and personal philosophy about genetic counseling can provide insight into how to approach counseling.[10] "Explaining complex medical and genetic information in a manageable and meaningful way is a challenge that demands time, consideration, and practice." [10, p.273] For those with a poor self-concept, the fear of doctors, the fear of being labeled, and the fear of stigmatization should be explored.[4] Through emotional support and understanding expressed by the counselor, the client's anger, guilt, or disappointment can be resolved.[10]

An issue that has received considerable attention,[4,13] concerns the type of counseling to be provided. Nonprescriptive (or nondirective) counseling, has been generally employed as a means of enhancing a client's self-esteem. Nonprescriptive counseling constructs the counselor as an information-provider. In nonprescriptive counseling, the counselor assumes a somewhat passive and neutral role. Prescriptive (or directive) counseling, on the other hand, presents the counselor as a facilitator of decision making. In this role, the counselor is balanced, reasonable and sensitive to the client's needs and understanding, but not neutral to the degree that he or she helps the client by sharing values and resources intended to enhance the ultimate outcome of the shared decision-making process. The counselor must carefully examine her or his own ethics regarding many of the issues surrounding genetic decision making. The counselor must also come to terms with and accept the client's decision when it runs counter to the counselor's own moral standards.

Expanded Roles of Rehabilitation Counselors

Several additional roles related to genetic counseling have been identified for rehabilitation counselors. These include educator, support person, and advocate. This author proposes an additional role: technical advisor.

Rehabilitation Counselor as Educator:

Education has been identified as prerequisite to the provision of genetic services, for both the general public and professionals.[3,13] With regard to education, the rehabilitation counselor can assist in several activities. First, the rehabilitation counselor can provide information on the genetic process and explain both procedures and results in ways that are meaningful to the client.[3,10] Specific tasks include providing information regarding diagnosis and prognosis;[10] medical procedures (testing, family planning options, etc.);[4] the need for a referral for more formal genetic counseling; advice on prenatal care; and assistance in preparation for parenting and related issues.[7,10]

Rehabilitation Counselor as Member of Support Network:

In the supportive role, rehabilitation counselors may perform a variety of services, including assisting families in identifying and addressing underlying psychosocial issues as they relate to genetic concerns ; referring families to support groups or organizing support groups for women and their significant others; assisting the client in making a decision and providing supportive follow-up; helping the client understand and deal with the reactions of other family members, ; establishing contact with someone who has had a similar experience to provide peer counseling); and placing supportive phone calls to family members and others identified by the client.[4,10]

Rehabilitation Counselor as Advocate:

In the role of advocate, the rehabilitation counselor may become involved with issues about discrimination, e.g., in areas of employment and insurance, as well as social discrimination.[8] Potential activities include educating employers and insurers about the client's legal protection and accommodations required for persons with disabilities; providing information to clients about their legal rights and to various ethics boards concerned with the practices and methods involved in genetic testing and counseling.[8]

Rehabilitation Counselor as Technical Advisor:

Finally, the rehabilitation counselor can assist the client by providing technical assistance. Technical assistance in genetic counseling issues can involve developing a Life Care Plan (LCP);[21] **the Life Care Plan provides an organized framework of services, recommendations, and requirements for long-term disability management, unique to the individual, that takes into account the rehabilitation needs of a person with a disability in all facets of life.**[21] The LCP can be used to identify potential services and costs that may be required for the child and family, as well as resources to secure such services. The LCP can also serve as a basis for planning such services so that no foreseeable lapse in the provision of services will occur.

Table I
LEVELS OF CRITICAL THINKING

LEVEL 1: Dualism / received knowledge

- At this level, individuals believe knowledge is a matter of simply collecting information or data from workshops and books.
- Information is believed to be either correct or incorrect.
- The concept of interpretation is itself perplexing. Often people will become irate or confused, and wonder why other people or authors don't just say what they mean.
- Individuals may resist critical thinking because they begin to see the world as far more complex than they realized.

LEVEL 2: Multiplicity / subjective knowledge

- Here, individuals begin to recognize that doctrines and opinions can and will conflict. In addition, they begin to see that conflict is a legitimate feature of knowledge.
- Unknowns, doubts, and uncertainties are acknowledged.
- Thinking is less dualistic and more multiple, or many-sided.
- At this level, people begin to recognize that knowledge and thinking is complex, but have not yet learned how to operate in it.

LEVEL 3: Relativism / procedural knowledge

- Here, people begin to realize that opinions differ in quality.
- They recognize that good thoughts are supported by good reasons.
- They begin to see that they must evaluate an issue in complex terms, weighing more than one factor in the attempt to develop an opinion.
- Attempts are made to understand another point of view, the reasons behind that view, and the thinking framework.
- They will take deliberate extensions into positions that initially feel wrong or remote.

Level 4: Commitment to relativism/constructed knowledge

- At this level, knowledge learned from others is integrated.
- Individuals begin to capture the interplay of rationality, caring, and responsibility.
- They become passionately engaged in the search for understanding.
- They become committed to nurturing rather than criticizing ideas.
- They seek integrated, authentic lives, and contribute to the empowerment and quality of others.

Ethical Issues

The provision of genetic information can serve an individual who either has a genetic disorder, or is a potential carrier of such a disorders, in helping them to make informed decisions. However, such information also imposes a burden of choices to be made, i.e., a choice of whether to have or not to have children, whether to undergo testing, and what actions to take if testing reveals a disorder.[3]

Ethical issues in genetic counseling focus on two stages.[7] **The first stage, the process of counseling prior to prenatal diagnosis, involves ethical responses to the client's inquiries about procedures and their uses;** this is an essential component of any genetic counseling. Advances in diagnostic measures are dramatically expanding the potential for genetic screening and prenatal diagnosis.[3,4] Of special note, Pembrey[3] contains an excellent and insightful overview of the genetic process. The Human Genome Initiative (HGI) is the response to new diagnostic and third-trimester dilemmas.[7] **Physicians can be of great assistance in referral to genetic experts, as well as in interpreting results of testing in light of family values. However, these same physicians must guarantee that genetic information about patients is kept confidential; every effort must be made to safeguard information which can significantly effect a patient's access to employment, insurance, and other resources.[12] Additionally, any research being carried out in**

areas of potential services must be disclosed to the client and informed consent must be obtained.[7]

Conclusion

Until recently, there has been a shortage of trained genetic counselors.[12] This is critical; genetic counseling concerns far more than preventing pregnancy by contraception or preventing birth by abortion.[11] Instead, it involves a complex, multidimensional process of presenting information designed to facilitate a decision that is best for the individual client. Genetic counseling might also be an area of specialization for rehabilitation counselors who wish to undergo further training in genetic issues.

Familiarity with genetic issues is salient to rehabilitationists; the rehabilitation counselor may be the one professional in the lives of rehabilitation clients that takes the time and effort to identify genetic issues for them. In the various roles that a rehabilitation Counselor can take in their client's lives it is imperative that that they possess at least a working knowledge of gentic issues. This is essential to the trust and confidence that must maintain for rehabilitation services to be truly efficacious.

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Questions Based On This Lesson

To earn CE credits, answer the following questions on your quiz response form.

9. Which of the following is *not* a role that a rehabilitation counselor may play in processing genetic issues with clients?

A. Member of support network

B. Decision maker

C. Technical advisor

D. None of the above

10. Which of the following is *not* an area in which the HGI is working in order to reduce negative consequences of genetic research?

A. Minimizing the impact of gentic research on the concepts of humanity and personal responsibility

B. Safeguarding the privacy of individuals and groups

C. Insuring that legal measures are in place to prohibit women from using gentic information in making the decision whether to abort a fetus or not

D. None of the above

11. The enormous increase in knowledge about the genome and the potential for intervention in gentic disorders has had which of the following effects?

A. Only negative effects on reproductive freedom

B. Putting potential parents in the difficult position of deciding whether to keep or abort a fetus which may be born with a hereditary disorder

C. The majority of potential parents now have prenatal testing done

D. Misperceptions of genetic disorders have virtually disappeared

12. Common reactions to the identification of a genetic disorder do *not* include which of the following?

A. Disruption of family dynamics and marital relationships.

B. Bonding to a pregnancy in the hopes that the child will be born without complications.

C. Increased difficulty in decision making.

D. Precipitation of a mood disorder.

Directions in Rehabilitation Counseling

Volume 12 · Lesson 4

Substance Abuse Treatment for Pregnant and Parenting Women

Rivka Greenberg, PhD, Judith Fry McComish, PhD, RN,
and Jennifer Kent-Bryant, MSW

Dr. Greenberg is Adjunct Assistant Professor, School of Medicine, Wayne State University, Detroit, MI.

Judith Fry McComish, PhD, RN is Assistant Professor, School of Medicine and College of Nursing, Wayne State University, Detroit, MI.

Jennifer Kent-Bryant, MSW, Grand Blanc Schools, Grand Blanc, MI.

Introduction

Substance abuse treatment and research addressing the needs of pregnant and parenting women is a relatively new phenomenon.[1,2] Historically, women who abused alcohol and other drugs, particularly during pregnancy, were greatly stigmatized.[3] Many feared criminal repercussions or the loss of their children if they sought treatment.[4] Within the last two decades gender-specific treatment has evolved philosophically and programmatically.[5] **The field of substance abuse treatment, which previously focused almost exclusively on men and concentrated on behaviors related to substance use, has expanded to encompass treatment programming that addresses the personal and family needs of women.**[6,7]

This lesson discusses issues related to substance abuse in women, highlights gender-specific substance abuse treatment programming, introduces a group therapy treatment model, and describes a loss and grief group therapy model. A case study of one client's experience illustrates the approach taken in a successful loss and grief group. The lesson concludes with a summary of key points.

Substance Abuse in Women

Drug use among women, particularly those of childbearing age, 12–44 years, is a critical health and mental health issue. Women from all racial, ethnic, and socioeconomic groups use both illicit and licit drugs.[8] Estimates from the National Household Survey on Drug Abuse indicate that women in this age group account for approximately 45% of illicit drug use in the United States.[9] While reported substance use rates for women are continually lower than those for men, the differences have lessened over time.[10] Based on extrapolated statistics, approximately 200,000 women died as a result of substance-related illnesses in 1994.[11] Substance use by women has repercussions on family members. It is estimated that more than 1.6 million women using drugs were living with their children. Maternal substance abuse affects the children biologically, through prenatal substance exposure, as well as environmentally.[12] The environmental impact results not only from the drug use itself, but also from factors secondary to drug use, such as inconsistent caretaking and increased violence.[13] The children of women who use drugs are at high risk for emotional, developmental, and academic sequelae.[14]

Although substance-abusing women usually have a drug of choice (i.e., one drug that they use predominantly), current research has identified that many are polydrug users (i.e., they use different drugs in combination). For example, a woman might use both cocaine and alcohol, or heroin and marijuana. **It should be kept in mind that women who abuse drugs may use both illicit substances** (e.g., cocaine, crack, heroin, amphetamines) **and legal substances** (e.g., alcohol, cigarettes, and prescription drugs).[8]

The development of the field of gender-specific treatment has led to research and an understanding of the special needs of defined groups of women, including lesbians and homeless women, as well as women from various cultural backgrounds, such as Native-American, African-American, European-American, Asian-American, Latina, and Pacific Island women.[15] As our clinical and research understanding of the specific needs of women becomes more defined, interventions appropriate to their needs are increasingly becoming implemented.

Health Status:

Women who abuse substances often exhibit greater health needs, particularly gynecological and obstetrical needs, than women in the general population, and they appear to be predisposed to more medical problems than male substance abusers.[16,17,18] In addition to the direct physiological effects that alcohol and drugs have on women, sexually transmitted diseases (including syphilis, chlamydia, and HIV) and tuberculosis are serious health concerns.[8] The effects of substance abuse on women's health is complex due to a variety of factors. Their poor health is related to unhealthy lifestyles including prostitution and living in violent environments, poor nutrition, and little consistent health or dental care, either prevention or treatment.[17] As a result, they often enter substance abuse treatment in poor physical condition.

Psychosocial Status and Mental Health Issues:

Understanding the psychosocial characteristics of women seeking treatment for substance abuse is important for treatment planning and treatment effectiveness.[19] **Many women enter treatment with dual diagnoses,[20,21] which frequently include affective disorders such as depression,**[22,23] mood disorders, and posttraumatic stress disorder.[24] It has been noted in many studies that women in treatment have low self-esteem and this has proven to be an important treatment consideration.[25,26]

Experience of both sexual and physical abuse has been reported as a major characteristic of women in treatment.[27] It is estimated that between 36% and 75% have a history of childhood sexual, physical, or emotional abuse.[27,28,29]

Many women in treatment are pregnant or parenting and this has ramifications not only for the women, but also for their children and families.[30] Familial patterns of substance abuse[31] have been identified in a number of studies. Environmental influences on substance use have been identified, including the effects of intergenerational substance use—which may encompass mother, father, siblings, and grandparents—peer influences, and age of onset. A history of dysfunction in the family of origin often affects the mothers' actions and relationships with their own nuclear families.[32] In addition to studies that have identified environmental influences, increasing evidence in the alcohol studies literature suggests a genetic predisposition to alcoholism in certain families.[33] Given the multifactorial influences on substance abuse, treatment must be multidimensional. The inclusion of parenting and family issues provides a holistic treatment approach that addresses the multiple needs of substance-abusing women.[34]

Gender-Specific Substance Abuse Treatment Programming

A continuum of treatment models has been developed to address the needs of women in the United States (Table 1), including short- and long-term treatment, outpatient and residential programs, and drug-specific interventions. However, it should be noted that, although the number of programs treating women has increased in the past few decades, there are still not enough programs to meet the identified needs.

Gender-specific treatment programs incorporate relationship issues as a fundamental part of recovery. Treatment programs that address the diverse needs of the substance-abusing population may have a variety of components, including those listed in Table 2.

In a review of the literature, Howell, Heiser, and Harrington[35] report that gender-specific, family-focused, and culturally sensitive programming, provided by multidisciplinary, relationship-oriented staff, are important components of successful programming for women. **Gender-specific treatment shifted from a male approach, which is authoritarian and confrontational, to an approach using the relational model. Acknowledging the integral part that relationships play in the psychological development of women and the need for empathic approaches has led to fundamental gender-specific programming changes.**[3,36] The relational model uses the "self-in-relation" theory,[37] which places the emphasis on psychological development through connection with others. Women bring to treatment many issues that are fundamental to the relational model. They include women in relationships (as daughters, partners, and parents) and in relation to violence that has been a central part of their lives.[3] As programs for women were implemented, specific needs became apparent. **Primary among them were the practical needs of women with children.** Many women were unable to access treatment without provisions for their children. At first, this generally meant childcare. However, as the effects of drug abuse on the family became more widely recognized,[2] some programs began shifting to an ecological, family-focused treatment approach.[38] **These programs provide prevention and treatment services for the children, as well as for the parents.**[39]

Table 1
TREATMENT MODELS

- Pretreatment
- Detoxification programs
- Outpatient methadone maintenance programs
- Outpatient treatment
- Residential or domiciliary treatment
- Self-help and support groups

Group Therapy

Therapeutic interventions used in gender-specific drug treatment are increasingly documented in the literature. These include psychotherapy and cognitive, family, and infant mental health therapies, as well as relapse prevention and behavior change techniques.[40] However, rigorous scientific studies on effective treatment methodolo-

Table 2
TREATMENT COMPONENTS

- Assessment and diagnosis
- Chemical substitution (i.e., methadone)
- Substance abuse therapy
- Group therapy
- Individual therapy
- Alternative medicine including acupuncture
- Health care
- Family services
- Parenting programs
- Case management
- Infant mental health services
- Educational, vocational, and life skills training

gies are scarce. This can be attributed to the difficulty of implementing applied research procedures in treatment settings with a substance-abusing population and to the newness of the treatment focus on women and their children.[41]

Until the advent of gender-specific treatment, the normative treatment approach was to establish sobriety before beginning to treat psychodynamic issues. The clinical literature increasingly suggests that this approach may not be the most appropriate for women's treatment and that addressing psychological issues should come sooner.[42] **While individual therapy approaches may be a fundamental part of treatment, the value of incorporating a group therapy approach is increasingly apparent.**

Group therapy has been identified as particularly suited to meet the complex needs of women in recovery. This approach is designed to increase knowledge of self and understanding of the other participants in a safe, accepting, and trusting environment.[43] The described group approach presented didactic education within a psychotherapeutic context. The women were presented with new concepts and new language within a structure that enabled them to immediately begin to use and practice what they had learned. The language and concepts were designed to help participants identify their feelings and to use them to express themselves. The group context provided them not only with a safe place, but with peers who were able to share their common experiences. Learning that others have experienced similar situations validates the participants' sense of reality and lessens their feelings of loneliness.

Loss and Grief Group Therapy

Loss is a theme commonly identified in the lives of many substance-abusing women. Further clinical assessment often reveals unresolved grief.[44] Broadly defined, loss may include traumatic or dysfunctional events, as well as separation or death.[45,46] Unresolved issues of loss and grief can have negative outcomes. However, it is not clear whether the problematic outcomes are predominantly associated with the loss or trauma, or with the lack of resolution of the issues.[47] Among the identified sequelae are depression;[27,48] post-traumatic stress disorder,[45] drug or alcohol abuse,[48] low self-esteem,[49,50] and difficulty establishing healthy relationships with significant others and with their children.[46]

Unresolved loss and grief issues are associated with drug use and can inhibit or prevent recovery.[51,52] Group therapy, focusing on loss and grief, has been identified as a valuable treatment approach providing the opportunity for women to explore common experiences in a supportive environment.[7,53,54]

Studies on substance abuse treatment for women indicate that those who stay in treatment longer have better treatment outcomes. [30,55,56] In one study of a loss and grief group,[26] it was found that women who participated in the group remained in treatment significantly longer than women who did not participate. **This suggests that participation in the loss and grief group influenced their retention in treatment, potentially enhancing treatment effectiveness,** in addition to any specific benefits that may have been derived from participation in the group.

The treatment program provided a mulitfaceted intake assessment protocol with treatment reviews every three months. At intake, the women were given a battery of biopsychosocial assessments, which included the Substance Abuse Subtle Screening Inventory (SASSI)[57] and the Minnesota Multiphasic Personality Inventory-2 (MMPI-2),[58] as well as a psychosocial history interview. In addition, for both clinical and program evaluation purposes, the women were assessed with The Center for Epidemiological Studies Depression Scale (CES-D),[59] the Hudson Index of Self Esteem (ISE),[60] and the Profile of Moods States (POMS).[61] Parenting attitudes were assessed using the Adult Adolescent Parenting Index (AAPI).[62] These instruments, and others for the children, were given over a two-week intake period by a multidisciplinary team, which included a clinical psychologist, substance abuse counselors, infant mental health specialists, speech and physical therapists, and an educational psychologist. At the end of the intake period, the multidisciplinary team met and developed an initial treatment plan based upon clinical observation, client input, and findings from the assessments. The treatment plan was then implemented and reviewed quarterly.

The loss and grief group was initiated by the infant mental health therapist. She had observed the themes of loss and grief in her sessions and in sessions with other counselors. An overwhelming number of women identified personal traumatic losses in their therapeutic work. It was felt that developing one group which, focused directly on these issues would address treatment needs not covered in other treatment components.

The objectives of the group were to (1) give didactic information on the nature and stages of grief, (2) help each woman to identify her sources of grief, and (3) to provide a safe, supportive place for each woman to tell her story using her new knowledge and language. **A key treatment component was the connection made by many of the women between their earlier losses, loss/separation with their children, and the ways their substance use and relapses were related to lack of resolution of their loss/grief issues.** For example, some women noticed that they experienced a relapse on the anniversary date of a significant loss.

The six-week format included both didactic information on the stages of loss and grief and traditional group psychotherapy. In addition to interpersonal interactions, the group structure included individual writing and reading, and personal written or artistic creations. Individual therapeutic sessions were used to augment group treatment as needed. The sessions had an identified focus. In session one, the overall structure was explained, group norms were developed, and story sharing within a safe environment was modeled. In session two, the emphasis was on acquiring didactic information about loss and grief, including Kubler Ross's[63] stages of grief as related to their personal feelings. Sessions three and four consisted of sharing stories using the knowledge of loss and grief and the language that had previously been introduced. Session five introduced strategies for coping with the grief and loss, and their relationship with substance use. In the final session, the women used their new coping strategies to put closure to the group. At the end of each session, every woman filled out a personal response sheet.

The following case study combines the stories of a number of participants to protect confidentiality. The case follows Katrina through a six-week program, highlighting the program structure and her own insights and development.

Case Study:

This case study describes a loss and grief group implemented at a residential substance abuse treatment program. The grief group met 90 minutes each week for six weeks. This was a voluntary closed group.

> **Katrina is a 23-year-old African-American single mother of Daniel, 6, and Carmaine, 2. She began using cannabis, at age 13, under her older sister's influence, and shortly after began drinking alcohol. When she was 15 years old, she began using crack cocaine, and her addiction level steadily increased until she entered treatment.**
>
> **Katrina dropped out of high school in the 10th grade and gave birth at age 17. She entered the protective service system with a charge of child neglect due to drug use. She was unsuccessful in outpatient treatment, and her children were placed in foster care. Residential treatment was ordered as a condition of reunification. At treatment entry, Katrina was diagnosed with polysubstance dependence and histrionic personality disorder. Initially, Katrina had a difficult time with the program structure. After 9 months in treatment, she was reunified with her children. A month later she began the grief group.**
>
> **At the individual presession meeting with the infant mental health specialist, Katrina immediately identified two losses: the separation from her children and her uncle's death. She had been raised without a father and her uncle had assumed this role.**

Session One:

At the first session, Katrina tearfully shared the experience of the protective service worker physically removing her children from her for foster placement. She also talked about not receiving emotional support as a child. She had not viewed this as a loss until others in the group discussed it in those terms. Finally, she mentioned the death of her uncle. At the end of the session Katrina indicated that she was relieved to be expressing these painful feelings.

Session Two:

As the sessions continued, Katrina used the Kubler-Ross stages of loss and grief to identify her use of denial.[63] She shared the loss of her children and uncle, and admitted that she generally dealt with loss issues by using denial. Katrina related that she refused to think about her uncle when he died, and refused to think about her children when they went into foster care because it was too painful. Katrina reflected that during each of these incidents, she increased her drug use. She now understood that it was to repress her awareness of what was happening.

Session Three:

Katrina attended the third session, but did not talk. However, she indicated on her response sheet that she had been tearful while others were telling their stories because she could relate to them. She began to realize that she was no longer alone and that the other members could help her through the grief process. She said that she was afraid to grieve.

Session Four:

During the fourth session, Katrina told in detail how she lost custody of her children. They were removed as a result of a drug raid in which she went to jail. At that time, her children went to court-ordered kinship care. When she was released from jail, Katrina picked up her children and went "on the run" with them. A family member convinced her to turn herself in, and she lost them for a second time when they were physically removed from her. Katrina admitted that this group had aroused strong emotions and she remained tearful throughout the session. Katrina brought up that she was having a difficult time in treatment and contemplated leaving. The group questioned her about denial regarding the loss of her children if she left treatment and asked if she was ready to endure another separation from them. She indicated that she would do whatever was necessary to remain with her children.

Session Five:

The fifth session was spent exploring anniversary reactions and how to positively commemorate losses. Katrina actively participated in this session. She talked about her new understanding of grief. She identified how she used a "happy face" to deny the losses she had experienced throughout her lifetime. Aware of her use of denial, she began to question other life experiences, for example, "Why did my mother leave me when I was a teen?" In her response sheet, Katrina indicated that she valued the loss and grief group and was sad to see it end. The group had enabled her to identify her denial and begin to explore the many areas of loss and grief in her life.

Session Six:

In the last session, Katrina commemorated her loss by writing a letter to her children. First, she apologized for their foster care placement. She acknowledged that it was a painful time for all of them. She further explained that the lifestyle she had led during their separation would not have been safe for them. She admitted that she had not been a good parent and said that this was a painful truth. Katrina told her children that she wanted their childhood memories to be happy, secure, and full of love. Finally, she let them know that the separation was not their fault, that she loves them and will continue to work on being the parent they deserve. Katrina shared that this group has allowed her to face her grief and that she understands that grieving is an ongoing process. Katrina indicated that she felt supported by the group and learned to gain support from a group.

Conclusion

Substance abuse is a national health and mental health care concern, and the need to identify effective interventions is paramount. The advent of gender-specific substance abuse treatment in the 1970s not only changed theoretical and philosophical approaches to treatment, but also contributed to a new paradigm in treatment approaches that evolve in response to client needs. The relational model has guided the implementation of programming that addresses the needs of women. Studies that demonstrate the effectiveness of this paradigm shift are increasing.[26,64]

The identification of critical clinical issues for women that are related to their substance abuse is fundamental to addressing client needs. Gender-specific treatment has increasingly combined these issues with appropriate treatment modalities. Group therapy is one treatment component which is proving effective. Research indicates that factors inherent in this treatment modality itself may facilitate healing. These factors include learning that others have experienced similar traumas, receiving advice, modeling successful behaviors of others, having a sense belonging, and gaining self-understanding and hopefulness.[65]

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Questions Based On This Lesson

To earn CE credits, answer the following questions on your quiz response form.

13. Which one of the following statements is correct?

A. The field of substance abuse treatment previously focused almost exclusively on women and not men.

B. Women who abuse substances often exhibit fewer health needs than women in the general population.

C. Women who abuse substances appear to be predisposed to more medical problems than male substance abusers.

D. Women who enter treatment do not usually have any incidence of previous sexual or physical abuse.

14. Gender-specific treatment programming:

A. Is based upon the traditional male treatment model.

B. Does not incorporate prevention and treatment services for children.

C. Incorporates the relational model in treatment approaches.

D. Focuses on substance use issues only.

15. The treatment components for women in substance abuse treatment:

A. Focus solely on substance use.

B. Has an authoritarian, confrontational underpinning.

C. Does not incorporate life skills training.

D. Approaches treatment from a multidisciplinary, multidimensional perspective.

16. The use of group therapy in gender-specific substance abuse treatment:

A. Has proven to be fundamental when incorporated into the individual therapy approach.

B. Was found to influence the retention of participants in treatment, thus potentially enhancing treatment effectiveness.

C. Is particularly suited to meet the complex needs of women in recovery.

D. All of the above

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Directions in Rehabilitation Counseling
Volume 12 Lesson 5

Ethical Issue Considerations Working with Multiple Rehabilitation Disciplines

Irmo Marini, PhD, CRC, CLCP, and Bruce Reed, PhD, CRC, CVE

Dr. Marini is an Associate Professor and Graduate Coordinator and Dr. Reed is an Associate Professor and Program Coordinator in Rehabilitation Counseling at the University of Texas-Pan American, Edinburg, TX.

Introduction

The past decade has seen a proliferation of managed-care organization (MCO) involvement in all realms of rehabilitation, from physical restoration to counseling. The cost-containment mandate of MCOs has forced contracted providers into greater accountability and instigated the review of service delivery for persons with disabilities.[1] Various organizations and professions evolve with these changes by reviewing/developing their standards of practice, codes of ethics, accountability, and marketability.

Rehabilitation counselors continue to be employed in new and diverse work settings where they encounter related professional disciplines with similar or differing values, job responsibilities, accountability standards, and ethics. The rehabilitation counselor may find that there are certain situations in which the variability of the different discipline's codes of ethics produce an ethical dilemma. **An ethical dilemma is essentially defined as a situation in which two separate courses of action are rational, mutually exclusive, and in which both may have a considerable consequence. Additionally, both positions can be supported by ethical principles and guidelines.**[2] This lesson addresses this potential difficulty by exploring the differences in codes of ethics and listing recommendations to help the rehabilitation counselor in times of ethical conflict. This lesson also outlines the differences between certification and licensure and describes the differences between several key ethics codes, including those for certified rehabilitation counselors, certified case managers, licensed social workers, certified disability management specialists, and licensed professional counselors. These professional codes and ethics structures are placed in historical context, noting their underlying similarities and differences. Recommendations for counselors in solving specific ethical dilemmas are discussed.

After studying this lesson the reader should recognize the essential discrepancies between ethical codes and know which codes have the most specific information and regulations in different areas of the rehabilitation professional's activities. The reader should be better equipped to develop methods for making the best decisions in a complex ethical situation using the guidelines provided at the end of this lesson.

Requirements for Rehabilitation Counselors and Other Mental Health Professionals

Rehabilitation Education:

The rehabilitation field has experienced a continued growth in numbers of rehabilitation counseling professionals and subspecialties as well. Individuals graduating with a Master's degree in rehabilitation counseling have a variety of potential credentialing/licensing opportunities available to them, many of which require minimal additional training or supervision. For rehabilitation counseling students graduating from a Council on Rehabilitation Education (CORE) accredited program, immediate eligibility is granted to sit for the Certified Rehabilitation Counselor (CRC) examination. Since 1993, the minimum education eligibility requirement for the CRC examination is a master's degree in rehabilitation counseling or a related counseling field.[3] Many such graduate programs are additionally designed to allow students to take the appropriate electives to meet the academic requirements for license as a Professional Counselor. In the state of Texas, as with many other states, however, students must also complete a 3,000-hour internship supervised by a Licensed Professional Counselor (LPC).

Certification versus Licensure:

How does certification differ from licensure? Certification is a voluntary process developed by a group (e.g., association) to promote a professional image. Although it is voluntary and not required to practice, certain programs such as Workers' Compensation, the State–Federal Vocational Rehabilitation Program, and various insurers have recognized the CRC's scope and standards of practice as the minimum requirement to work with their constituents. The Commission on Rehabilitation Counselor Certification (CRCC) was the first national certifying body in the field of counseling.[3] With a primary focus on clients with disabilities, these professionals provide counseling-related services involving the physical, cognitive, and psychological functioning of their clients. Over 14,000 counselors have obtained their certification as a rehabilitation counselor certification since the inception of the CRCC in 1973. To become certified, an individual must obtain a passing grade on this nationally administered examination.

Licensure, on the other hand, is a statutory process, generally provided by a state, which grants permission for a qualified individual to engage in a profession and use a title.[4] Licensure is a state legislative issue. **Each state has the authority to create ". . . its own set of administrative laws and regulations setting forth criteria for obtaining authorization to practice as (or, in some states, to identify oneself as) a psychotherapist or counselor."**[5] Currently, 45 states and the District of Columbia have professional licensure laws.[6] Hawaii, Minnesota, Nevada, and New York have no such laws, while California's law pertains to licensed family and marriage therapists only. The most common title granted by the States is the LPC, although there are other titles, such as Licensed Mental Health Counselor and Licensed Clinical Professional Counselor. With 46 individual state licensing boards, there are variations in actual codes, standards, enforcement, and disciplinary procedures.

Related but Distinct Disciplines

As rehabilitation counselors continue to work with professionals in a growing number of related disciplines, they must be aware that these professions have their own codes of ethics. Some of the related professional entities include the Commission on Certification of Work Adjustment and Vocational Evaluation Specialists (CCWAVES), Certification of Disability Management Specialists Commission (CDMSC), Commission for Case Manager Certification (CCMC), American Psychological Association (APA), American Board of Vocational Experts (ABVE), the American Counseling Association (ACA), National Association of Social Workers (NASW), Commission on Disability Examiner Certification (CDEC), International Association of Rehabilitation Professionals (IARP), and the American Nursing Association (ANA). The range of educational requirements for certification with these entities ranges from no more than a high school diploma to a minimum of a master's degree. Since it is beyond the scope of this lesson to discuss the code of ethics for each of these organizations, we will focus on ethical considerations for certified rehabilitation counselors (CRCs) in comparison with the ethical codes of licensed social workers (LSWs), certified case managers (CCMs), certified disability management specialists (CDMSCs), and professional counselors (LPCs). These entities were selected because rehabilitation counselors may possess these other licenses/certifications and/or work closely with professionals who have one or more of them.

Certified Rehabilitation Counselors

A code of ethics for rehabilitation counselors was first devised in 1972 by the National Rehabilitation Counseling Association[7] and further refined in 1987. **The rehabilitation counseling code of ethics has five underlying principles: (1) *beneficence*, concern for the client's well being; (2) *nonmaleficence*, taking care not to cause harm to the client; (3) *autonomy*, respect for the client's ability to make choices; (4) *justice*, the ability to treat all clients equally and fairly; and (5) *fidelity*, keeping commitments to clients.[8,9] These five philosophical principles provide the foundation for the ethical behavior of the profession.** Overall, the CRC Code of Ethics places a high value on professional relationships that encourage dignity, caring, and autonomy for the client. **Philosophically, the client's right to make decisions (autonomy) and be fully involved in the process seems to take precedent over the other philosophical principles.**

As stated in the Code's preamble,[3] there are two kinds of standards in the Code; *Canons* and *Rules of Professional Conduct*. Canons are intended to provide broad guidance and direction to counseling professionals. They establish accepted standards of excellence to which counselors should aspire. There are 10 Canons within the Code that cover the topics of **moral and legal standards, counselor–client relationship, client advocacy, professional relationships, public statements/fees, confidentiality, assessment, research activities, competence, and CRC credential.** Each of the 10 Canons has multiple Rules that provide more specific standards to which the practicing professional must comply. There are a total of 72 Rules contained within the Code focusing on appropriate and inappropriate behaviors between professional and client.

Although it is the goal of the Code, and specifically the Rules, to provide specific, concrete guidance to professionals, Code of Ethics guidelines remain relatively broad.[7] The Code contains areas that are vaguely addressed, such as the possible powerful role of the extended family in the rehabilitation process (Rule 2.7), especially in the case of ethnic minorities.[10] **The potential impact of such variables as gender, ethnicity, sexual preferences, and religious affiliations are not adequately addressed.** The Code does include two Rules that address the issue of unethical sexual relationships between counselor and client but provide little specific information on defining sexual contact or sexual activities.

Certified Case Managers

Case management and its related organizations have experienced the most rapid growth of all during the past decade. With the concomitant reform of managed care, the number of practicing case managers has grown from an estimated 5,000–10,000 in 1985, to somewhere between 50,000 to 100,000 in the 1990s.[11] There are an estimated 20,000 CCMs representing various disciplines, including rehabilitation counseling, nursing, social work, case management, physical/occupational therapy, and medicine.[12] The first CCM exam was written in 1993. [12] It is important to note that the Commission on Case Management Certification (CCMC) is a separate and independent entity from the Case Management Society of America (CMSA). The CCMC represents the certifying body of case managers, whereas the CMSA is an international, nonprofit organization which was founded in 1990 and which has over 160 affiliated chapters worldwide.[13]

Tarvydas and Peterson[14] argue that **case management may not be a separate profession but is rather an "advanced practice" credential, available to professionals who have received prior training in their core profession. The CCM code of ethics, revised**

May, 1999, notes under its scope of practice that case management is indeed not a profession but rather an area of practice within a transdisciplinary profession.

In 1995, the CMSA consolidated with the Individual Case Management Association (ICMA) to become CMSA, and released its standards of practice for case management in 1996 as well as a National Board peer-reviewed code of ethics. CMSA diversity is evident in its 14 special-interest groups focusing on: academics, acute care, behavioral health, business owners, managers/supervisors, disease management, elder care, home care, managed care, rehabilitation, subacute care, workers' compensation, military, and pediatric care.[13]

Ethical Differences:

The fact that CCMs are themselves from multiple disciplines can present ethical dilemmas for those individuals who have additional certifications or licenses, which may conflict with the CCM code of ethics. For example, a certified rehabilitation counselor's code of ethics places client interests first, whereas the CCM's code defines case management as:

> **A collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options and services required to meet an individual's health needs, using communication and available resources to promote quality, cost-effective outcomes.**[15]

Rinas and Clyne-Jackson[16] described situations in which ethical dilemmas can arise from conflicts of interest when holding certifications with differing codes. The CRC who carries both certifications or works with a CCM wrestles with the issue of whether the client's or payer of service's needs come first. In the preamble for both CCMC and CDMSC, it is noted that the term "client" refers to the individual for whom services are provided, and the term "payer" refers to the certificant's "customer."[15,17] The CCMC code openly acknowledges that, because of the different interests of client and customer, case managers frequently find themselves in ethical dilemmas.

The other ethical issue described pertains to the difficulty for case managers in having to abide by the CCMC code of ethics as well as the code for their primary profession. Tarvydas and Peterson[14] **note how one could interpret the CCMC code as a shift in paradigms away from exclusively client-centered health care.** Marini[18] noted these same concerns regarding conflicts of interest in delineating who is the client, especially in private for-profit environments.

The CCMC's standards of practice and code of ethics were developed primarily by a committee of nurses, and the standards closely model the structure used by the American Nurses Association.[14] The CCMC's code contains eight *Principles*, which are advisory only, and are not enforced. **The Principles are general in nature and are consistent with other codes in that they reflect priorities to the public interest, respecting and protecting client welfare, maintaining objectivity, maintaining competency, remaining within one's area of expertise, obeying laws and regulations, and respecting other professionals.** There are also eight generic, but mandatory *Rules of Conduct* pertaining to falsifying documents, conviction of a felony, falsely using the credential, breach of conduct, failure to pay fees, and failing to maintain the CCM title. It is interesting to note that the last two Rules are not found in the other entities discussed here. In fact, by deciding not to continue practicing with the CCM credential, one is violating a rule! **Finally, there are 27 mandatory *Guidelines for Professional Conduct* which, when compared with CRC's rules, are quite brief and limited in application.** The CRC code,[19] for example, contains one canon regarding the Counselor–Client Relationship and, separately, a canon on Professional Relationships, with 9 and 11 rules subsumed within each Canon, respectively. The CCMC Guidelines, however, contain a one-paragraph rule on Dual-Relationships and one sentence regarding Relationships with Clients.[15]

One of the underlying values in the CCMC code is that of "achieving client wellness and autonomy through advocacy."[15] These concepts are not cited in the Rules of Conduct or Guidelines, but rather in the CCMC preamble, thus only making them aspirational in nature and not subject to compliance or violation penalties. Beauchamp and Childress[20] state that the right to self-determination and freedom to choose components define the principle of autonomy. Goldman[21] argues that health care consumers are often not given options to make an informed choice, while Nelson and colleagues[22] state that clients in these situations often do not have the freedom to choose. **For counselors who are CRC and adhere to the CRC code of ethics regarding the principle of autonomy, working as a CCM in a restrictive insurer environment compromises consumer autonomy when ideal consumer services are cost restrictive.**

One final factor that differentiates the CCMC code of ethics from the CRC, LPC and LSW codes deals with Guideline 25, regarding Solicitation:

> **Certificants shall not reward, pay, or compensate any individual, company, or entity for directing or referring clients to the certificant. Nothing contained herein shall preclude certificants from making reasonable expenditures in entertaining individuals who have referred or may in the future refer clients to the certificant or from giving gifts of minimal value to such individuals.**[15]

This statement contradicts the CCMC code's underlying values of client autonomy through advocacy and empowerment of clients. **The guideline does show indications of the competitiveness of the managed-care market** and the continuing ethical dilemmas that case managers often encounter.

Professional Counselors

In the broad field of professional counseling there is much variability on such basic issues as educational training, roles and functions, work settings, and credentialing. There is no clear consensus on what a professional counselor is or how to regulate the profession. This reality can cause confusion for people in need of services as well as those entering the field. One definition of a "professional counselor" is a professional with a minimum of a master's degree along with relevant skills and experiences that allow him or her "...to facilitate human development and adjustment throughout the life span."[6] Professional counselors can come from a variety of educational backgrounds (e.g., psychology, counselor education, rehabilitation, guidance, and counseling) and work in varied settings, including mental health agencies, schools, rehabilitation settings, and many community settings.

Within the counseling field are professional organizations that provide certifications (national focus) as well as licensure (as dictated and monitored by each state). There are currently two national counselor certification boards: the Commission on Rehabilitation Counselor Certification (CRCC), established in 1973, and the National Board for Certified Counselors (NBCC), which was founded in 1981.[6] The NBCC has four areas of specialization; career, gerontology, school, and mental health counseling. Membership in both organizations is voluntary and monitored by the respective professional organization.

The American Counseling Association (ACA) is a leading professional organization that currently represents approximately 52,000 counselors nationwide. The ACA developed its first Code of Ethics and Standards of Practice in 1961, with the most recent revisions occurring in 1995.[23] While this code does not supercede state licensing board codes, it is widely recognized in the field as representing the broad field of counseling. It is important to note that a counselor can be a member of ACA and not necessarily be certified.

Ethical Differences:

The ACA Code is divided into two parts; the *Code of Ethics*, which consists of broad principles that describe ethical professional behavior, and *Standards of Practice*, which dictates minimal standards of behaviors and practices.[23] **Both parts are subdivided into eight sections: counseling relationship; confidentiality; professional responsibility; relationships with other professionals; evaluation and assessment; teaching, training, and supervision; research and publications; and resolving ethical issues.** Sections are further divided into two sublevels by designation of numbers and letters. For example, the designation "B.1.d" discusses Confidentiality, Right to Privacy, and Contagious, Fatal Diseases. Included in this system are references (sometimes referred to as "cross-walks") to other related codes or standards within the document.

Client–counselor relationships, including confidentiality, client's rights, and situations requiring disclosure of client information, are core to this code. Ethical relationships between professionals is another important theme. The entire section dedicated to the teaching, training, and supervision of new counselors is of note; **components such as the training requirements of student supervisors, the need to present varied theoretical perspectives, and the responsibility to teach and discuss ethics are detailed.**

It must be emphasized that the ACA Code of Ethics and Standards of Practice is not the individual state licensing code. As previously stated, each licensing body has it's own code. Differences can, and certainly do, exist. One example is the code from the state of Texas for Licensed Professional Counselors. Although the general themes and major issues greatly overlap, there are different emphases. The Texas code provides little discussion of the client–counselor relationship, except in the area of sexual misconduct. Great effort is made attempting to define and give examples of inappropriate behaviors and contacts; nine subsections, each with further division, cover this topic. Other areas, such as the role of testing and research, are minimally discussed compared with the ACA Code.

There are notable differences between the ACA and CRC codes. The ACA code dictates that, under certain conditions, sexual intimacy with former clients is allowable two years after the completion of services. This code also states that counselors do not provide clinical services to former partners. The CRC code more simply states in various rules, such as R2.3 and R4.8, that sexual relationships with clients are unethical. Potentially, this difference in interpretation of sexual relationships, a highly charged topic, could cause professional and personal conflicts as relationships may be acceptable (two years after treatment ends) by one profession but be deemed unethical in the other.

As professional counselors tend to work in group counseling settings more than rehabilitation counselors do, **the ACA code contains more guidelines related to groups and family counseling.** Another difference between the codes is in the area of computer technologies. **In Section A, Counseling Relationship, of the ACA code are specific guidelines on the appropriate use of computers by clients during clinical services.**[6] For example, one guideline states that the counselor must ensure that the client is physically, cognitively, and emotionally capable of using the selected computer application. The CRC code has no guidelines on computer use in the counseling relationship to date.

Social Workers

As licensed professionals, social workers are required to follow licensing standards within the state that they work. This can result in slightly differing standards from state to state. However, all of the social work codes and standards of practice are based on the same values and ethical principles upon which the profession was founded.[24] The National Association of Social Workers (NASW) is the largest professional organization for social workers worldwide, representing over 155,000 members.[25] NASW was formed in 1955 and adopted its first code of ethics in 1960.[26] The most recent revision occurred in 1999.

Ethical Differences:

The NASW code is divided into two main sections. Section I is entitled "Ethical Principles" and delineates inspirational ideals in the form of six key values and ethical principles: **(1) *service*, the primary goal of social workers is to help people in need and to address social problems; (2) *social justice*, social workers challenge social injustice; (3) *dignity and worth of the person*, social workers respect the inherent dignity and worth of the person; (4) *importance of human relationships*, social workers recognize the central importance of human relationships; (5) *integrity*, social workers behave in a trustworthy manner; and (6) *competence*, social workers practice within their areas of competence and develop their professional expertise.**[25]

Section II of the code, "Ethical Standards," contains six primary parts that cover the broad areas of ethical responsibilities to clients, to colleagues, as professionals, to the social work profession, and to society. Each of these six parts contains relevant standards. For example, the section on ethical responsibilities to society states that social workers should provide professional services in times of public emergency.

Consistent with the values of the profession, the code and standards articulated by NASW reflect a strong commitment to the dignity and confidentiality of the individual in need. Values related to service to those in need and society-at-large, including confronting social injustices, are also woven throughout this document. An example is Standard 3.10, Labor-Management Disputes, which states that social workers may become involved in organizing labor unions, strikes, etc., when improvement of the workers' condition is warranted. In comparison, the CRC Codes call for a different type of action; it requires the professional to advocate for people with disabilities in the areas of accessibility, employment, and the elimination of attitudinal barriers.

The NASW code has considerably more discussion on sexual relationships than does the CRC code. NASW states, for example, that social workers should not engage in sexual activities with clients under any circumstances. Services are also not to be provided to individuals who are former sexual partners. As previously mentioned, the CRC codes basically state that sexual relationships are unethical.

The CRC code mentions specifically in R1.3 that counselors will be aware of the potential differences between legally mandated laws versus professional guidelines and standards. It is clearly stated that the CRC will follow legal mandates as a priority. The NASW code makes no similar statement.

Certification of Disability Management Specialists Commission

The Certification of Disability Management Specialists Commission (CDMSC), formerly called the Certification of Insurance Rehabilitation Specialists Commission, is responsible for an emerging area of specialization for rehabilitation counselors. Counselors with this certification typically work in employer-based settings and provide medical and vocational case management as an employee of the company to injured workers onsite or in-house.[27] This return-to-work approach ideally creates a "win–win" situation for the employer and employee by saving the employer compensation and health care costs, and returning the employee safely back to work as soon as possible.[28] The CDMSC maintains a very similar (in some cases identical) code of professional conduct to that of the CCMC.

Ethical Differences:

Here again, the distinction is made in the CDMSC Preamble that the individual for whom services are provided is the "client." while the payer is referred to as the "customer."[17] Tarvydas and Peterson[14] state that the "CDMSC acknowledges the fact that CDMSs are employed by entities that have a primary interest in controlling costs as opposed to providing services that achieve the maximum benefit for the client."[17]

The CDMSC Code consists of two kinds of standards: Principles, and Rules of Professional Conduct (RPC). As with the CCMC, the eight Principles are advisory only, while the 29 RPCs are mandatory where violations can be sanctioned. As noted earlier, the 29 RFCs are quite brief (one sentence to a paragraph) in explanation when compared with the CRC code. Under RFC #2 regarding competence, for example, certificants shall not handle or neglect a case in a manner that constitutes gross negligence, which is defined as "willful, wanton or reckless disregard of the certificant's obligations and responsibilities."[17] In this instance, what exactly constitutes a violation of this rule is highly interpretable.

The CDMSC also has an RFC regarding confidentiality and disclosure; however, it differs from CRCs in that clients must always be informed at the outset that any information obtained from the insured injured worker may be disclosed to third parties (insurer). The CRC code addresses this issue under Rule 2.4 of counselor–client relationships. **For CRCs who have traditionally never worked with third-party insurers, this conflict may present an ethical dilemma in which the counselor must redefine the concept of "confidentiality."** It does stand to reason that, since they are paying the bills, insurers are entitled to receive progress reports; however, ethical problems can arise for counselors if or when adjusters attempt to curtail costs of a counselor's proposed rehabilitation plan.

Another difference between the CRC and the CDMSC codes relates to RFC 9, "Business Relationships with Clients." This Rule notes that counselors are prohibited from entering into a business relationship with former clients for one full year after a case has been closed. The CRC code does not place a time limit on such dual relationships.

Codes of Ethics Underlying Similarities

Despite the differences in ethical codes described above, at the core of each of the human services' code of ethics are some fundamental similarities. **Ethics writers[4,5,23] site four principles that organize the major content of these codes:**

- Act to benefit others
- Professional responsibility and competence
- Integrity in professional relationships
- Public trust in responsibility to society

It is important for rehabilitation and other counselors to know how legal principles interact with ethical standards. Of particular significance are issues such as dual-role relationships, duty to warn, professional disclosure and informed consent, competency in one's area of expertise, confidentiality and privilege, and criminal/civil liability.

These codes of ethics differ most in their brevity or comprehensiveness rather than in their intentions. All the codes essentially overlap in the areas of moral/legal standards, counselor–client relationship, professional relationships, public statements/fees, confidentiality, competence, assessment, and research activities. Of the five codes reviewed here, the most comprehensive set of ethical codes was that of the professional counselor. The least concise set of codes was that of the case managers and disability management specialists.

Table 1
RECOMMENDATIONS FOR REHABILITATION COUNSELORS

- **Certified rehabilitation counselors who hold other certifications and/or licenses should defer to the most detailed set of ethical guidelines when needed. Counselors must also take into consideration the setting and circumstances in which they are working.** For example, even though the CRC code is more detailed than the CCM code, if an individual holding both credentials worked in a private for profit setting answering to an insurer, he/she would be bound to the policies and procedures of that setting, which may not necessarily place the client's needs first regarding costly services.

- **When faced with an ethical dilemma that a Counselor's code of ethics does not address (e.g., use of the Internet to counsel clients for CRCs), the rehabilitation counselor should seek out advisement from his or her certifying body's ethics committee.** If this fails, the counselor could review/consult with a knowledgeable colleague or another counseling body that has ethical conduct guidelines for a certain activity. Following such steps may hold some minimal merit in a court of law.

- When working with multiple disciplines, rehabilitation counselors can benefit from adopting the **Integrative Decision-Making Model of Ethical Behavior,[14]** which addresses underlying themes of which counselors should be aware. Tarvydas[29] **outlines the four stages of this model: (1) interpreting the situation through awareness and fact-finding; (2) formulating an ethical decision; (3) selecting an action by weighing competing, nonmoral values; and (4) planning and executing the selected course of action.**

- Rehabilitation counselors should be aware that currently the CRCC does not address Internet communications or counseling, sparsely addresses the role and importance of family among ethnic minorities, and does not place any time limits as to if or when rehabilitation counselors could begin a dual relationship after a client's case has been closed.

- As of 1999,certified rehabilitation counselors must have a minimum of 10 continuing education credits devoted specifically to ethics within their five-year renewal period. **This requirement indicates the importance for Counselors to periodically review their Code and refer to it during times of uncertainty.**

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Questions Based On This Lesson

To earn CE credits, answer the following questions on your quiz response form.

17. What is (are) the primary concern(s) that Rinas and Clyne-Jackson discuss for a CRC working with a CCM or who carries both certifications?

A. The code was developed by a team of nurses and so the CCMc guidelines closely resemble the structure of those of the ANA.

B. The CRC must decide whether the client's or customer's (as defined by the CCMC guidelines) needs come first.

C. The difficulty of abiding by both CRC and CMCC guidelines, especially when the CCMC code can be interpreted as a shift away from client-centered-health care.

D. B and C

18. In what area is the ACA's Professional Counselor Code more detailed than the CRC code?

A. The potential for the extended family to be involved in the treatment process, especially for patients from ethnic minority groups

B. Sexual conduct and computer technologies

C. Sexual conduct, computer technologies, and group and family counseling

D. The impact of gender in treatment

19. An ethical dilemma is essentially defined as:

A. Situations where a rehabilitation professional differs in opinion from that of the client regarding needed course of action.

B. Two separate courses of action which are rational, mutually exclusive, and in which both may have a considerable consequence.

C. Two or more courses of action which may or may not be exclusive and which have considerable consequences.

D. Two separate courses of action which appear to be unethical, mutually exclusive, and in which both may have a considerable consequence.

20. What should a CRC with other certifications do when he or she is faced with an ethical dilemma?

A. Refer to the most detailed Code that applies to them.

B. Seek out advisement from one of their certifying bodies if none of the codes addresses the issue.

C. Consult with a knowledgeable and experienced colleague.

D. All of the above

Directions in Rehabilitation Counseling
Volume 12 Lesson 6

The Psychosocial Impact on Survivors of Extraordinary, Stressful, and Traumatic Events:

Principles and Practices in Critical Incident Response for Rehabilitation Counselors

Mark A. Stebnicki, RhD, CRC, LPC, CCM

Dr. Stebnicki is Associate Professor and Director, Masters Program in Rehabilitation Counseling, Department of Rehabilitation Studies, East Carolina University, Greenville, NC

Introduction

Extraordinary, stressful, and traumatic events such as natural events (e.g., hurricanes, earthquakes, floods); crimes (e.g., school shootings, robbery), or catastrophic injury and illness (e.g., SCI, HIV, AIDS) are common experiences in the lives of many Americans.[1] In fact, it is estimated that the typical American will spend nearly 12 years of his or her life in a state of limited psychosocial functioning because of chronic illness and disability acquired through disease or injury.[2] **Regardless of how close one is to the "epicenter" of a critical event, the "aftershocks" significantly effect the physiological, social, emotional, psychological, and social functioning of the survivor, family members, the community, and the professional helpers.[3]**

Extraordinary stressful and traumatic events also occur in the workplace and contribute to the syndrome known as occupational stress. For example, Bachman[4] reports that the U.S. Department of Justice has documented more than 2,406 deaths due to violent crimes between 1995 and 1996. Additionally, more than 1 million people per year are survivors of work-related rapes, physical assaults, and robberies.[5] These figures may be underreported because many victim/survivors do not report crimes immediately, or at all, after they have occurred.

The defining characteristics of most critical incidents are the individual's perception of the potential threat to their survival and the perception that the event itself is both uncontrollable and unpredictable.[6] Psychoso-

cially, it is recognized that individuals who are directly affected by traumatic events must try to adjust and adapt physically, psychologically, socially, vocationally, and economically, as well as in many other ways.[7] Consequently, some survivors are at risk of experiencing clinical symptoms identified with posttraumatic stress disorder (PTSD).[8] **Interventions that promote survivors to communicate their reactions to traumatic events in detail will decrease the severity, intensity, and frequency of long-term PTS.**[9] Accordingly, many schools, human resource departments, and victim assistance programs have called upon professionally trained crisis counselors to provide critical incident stress debriefings to small and large groups of people who have been affected by traumatic events.

Role of the Rehabilitation Counselor:

Many Red Cross volunteers and other mental health counselors have been trained in crisis response and critical incident stress debriefing. However, rehabilitation counselors have had little preparation for the role of assisting survivors of critical incidents. **Rehabilitation counselors, by virtue of their training and expertise in dealing with issues of loss, grief, psychosocial adaptation, and adjustment to chronic illness and disability, appear to be uniquely qualified to provide crisis response to small and large groups of individuals once they have undertaken some further training in crisis intervention.**[5,10]

Providing small and large group critical incident response to deal with the psychosocial aftershocks of individuals in crisis appears to be a new direction of training and research for rehabilitation professionals in the twenty-first century. Hence, this lesson aims to: (a) provide rehabilitation professionals with an understanding of the significant impact of group-related critical incidents and the psychosocial response of survivors, family members, counseling professionals, and the sociocultural community environment; and (b) offer brief, solution-focused strategies for coping with the acute, post-, and secondary traumatic stressors associated with crisis events.

Shifting Definitions and Assumptions Regarding Crisis Response

Crisis response is not a new phenomenon in the counseling and mental health field. In the early 1970s, the psychology and counseling literature was replete with brief and immediate interventions for clients who were in crisis.[11-13] Because of increasing trends in violence against groups of people (e.g., minority groups, school children, work-related violence) there is a need for trained and qualified crisis responders who can intervene with people who are directly (*primary survivors*) or indirectly (*secondary survivors*) affected by the aftermath of extraordinary stressful and traumatic events. These acts of interpersonal violence require a unique understanding and set of strategies to facilitate brief and immediate interventions. Accordingly, the terminology, concepts, and strategies used to characterize principles and practices in crisis response appear to have shifted. The focus in crisis response has changed primarily because of the following:

- **Nature and severity of critical incidents (e.g., increase in school and workplace violence resulting in multiple deaths)**
- **Types of interventions and services provided (e.g., group stress debriefings, defusings with public and private entities)**
- **Shift toward serving different groups of primary and secondary survivors (e.g., paramedics, police, nurses, counselors)**
- **Research suggesting that immediate and brief interventions will decrease the negative long-term symptoms associated with PTS (e.g., depression, suicide, nightmares)**

Definitions:

The following is a brief list of definitions that refer to more recent principles and practices in crisis response.[14]

Extraordinary Stressful and Traumatic Event
(also referred to as a Critical Incident or Crisis Event)

A sudden stressful or traumatic event that is typically outside the normal range of ordinary human experience and is so overwhelmingly stressful to an individual or group that, initially, they have little or no coping skills they can use in dealing with the event.

Critical Incident Stress Debriefing (CISD)

CISD refers to a formal, structured protocol originally developed by Mitchell[15] as a direct, action-oriented crisis intervention process designed to prevent traumatic stress symptoms for both primary and secondary survivors. CISD is recognized as the most widely used among disaster response teams and military and emergency service personnel. [16] CISD is a team-oriented approach, a group process, and should not be a substitute for psychotherapy. The purpose of using a CISD approach is to provide stabilization for the group, mobilizing the groups resources, and to restore function to the group members.

Critical Incident Stress Management (CISM)

CISM uses a comprehensive team approach of stress management education, programs, interventions, and strategies designed to prevent PTS and Secondary Traumatic Stress (STS) in primary and secondary survivors. The function of the CISM team is to serve as the "first line of defense" against traumatic stress. [14] After a critical incident, the CISM team can be called into action rapidly to provide group debriefings.

Debriefing

Debriefing is a generic term, originally used by military personnel, to describe an approach that involves forming small and large groups of primary and secondary survivors to educate and discuss one specific critical incident. Debriefings typically last 60–90 minutes and are facilitated by trained and qualified group leaders. Sessions focus primarily on the ventilation and validation of the individuals' and groups' emotional and psychological health as impacted by the traumatic event. Debriefings also use prediction and preparation interventions to help facilitate resources and coping skills among the group of survivors. The National Organization for Victims Assistance (NOVA) uses a group debriefing model as the primary intervention. [17]

Defusing

Defusings are basically a shortened version of the CISD model. They are designed to either eliminate the need for a formal debriefing or enhance the CISD. Defusings take place immediately or relatively soon after the critical incident and include three parts: introduction, exploration, and information. [14]

Assumptions:

It is currently recognized that both the primary and secondary survivors of extraordinary stressful and traumatic events are at risk for PTSD and STSD. [3, 14] Figley distinguishes PTSD from STSD stating: "STSD is a syndrome of symptoms nearly identical to PTSD, except that exposure to knowledge about a traumatizing event experienced by a significant other is associated with the set of STSD symptoms, and PTSD symptoms are directly connected to the sufferer, the person experiencing primary traumatic stress."[3 (p.8)] Accordingly, crisis responders should be knowledgeable and mindful of the following factors when providing interventions.

1. ***Recognize the person as a survivor.*** **Viewing people as "victims" of traumatic events discounts their survival skills and negatively reinforces the stereotype of being helpless, hopeless, dependent, and defenseless. Although the person may be a victim of a crime, perceiving and intervening with individuals in this role will hinder their ability to cope and adapt.**
2. ***Accept that the stressors accompanying traumatic events are real and legitimate for survivors.*** **People involved with extraordinary stressful and traumatic events will typically be physiologically and psychologically affected and will require some short-term therapeutic interventions. This does not mean that the person is "going crazy" or "emotionally weak."**

Rather, the physiological and psychological effects are normal responses to an extraordinary stressful event.

- ***There is a high incidence of PTS and STS that affects secondary survivors as well.*** The phenomenon of "vicarious victimization" suggests that persons can acquire posttruamatic stress disorder (PTSD) or STS by having indirect exposure to violent events.[17]

- ***Depending on how close the professional counselor is to the "epicenter" of the crisis event, he or she may also be at risk of experiencing the stressors associated with being a secondary survivor.*** If these stressors go unrecognized, professional counselors may experience the emotional, mental, and physical exhaustion associated with empathy or compassion fatigue.[18]

- ***Interventions should be person centered, as opposed to treating a diagnostic category.*** The DSM-IV[19] does not allow PTS "disorder" to be diagnosed until 30 days after exposure to traumatic events. Regardless, primary and secondary survivors are affected by traumatic events and respond in many different ways. People who report a history of trauma are not members of a homogenous population. Thus, treatment efforts must consider unique individual and environmental characteristics by focusing on symptom relief of the person's acute stress and coping strategies.[20] Regardless of the results of the person's DSM-IV clinical assessment (i.e., PTSD), the individual's previous response and coping mechanisms after prior traumatic events may offer more insight for brief or solution-focused interventions.

- ***Professional counselors must view the survivor in relationship to his or her cultural, sociopolitical, and institutional environment, and assess which factors may hinder the ability of the person (or group of people) to cope and adjust.*** Rehabilitation has always emphasized the role environment plays in dealing with the stress of and emotional response to disability.[21] Thus, mental health problems associated with the traumatic event do not reside solely within the individual.

- ***Empowering survivors with multiple resources and support systems will facilitate better coping abilities and recovery.*** Family, friends, churches, and other support groups can be a major source for coping and psychosocial adaptation.

- ***Individuals heal at different rates.*** Coping abilities and adjustment to the grief and loss associated with traumatic events vary from person to person and do not fit neatly into a theoretical stage model of adaptation or adjustment. Victor Frankl[22] sums up this point by suggesting that it is not necessarily the nature of the trauma itself that will most affect one's ability to cope psychologically with its consequences, but rather, the person's own attitude toward the trauma.

- ***Preexisting physical, emotional, cognitive, or financial limitations may intensify a crisis event and produce more complex reactions of grief and loss.*** People with disabilities, such as life-threatening illnesses, may be at risk of increased psychological and emotional trauma following a critical incident.[23] Thus, preexisting chronic illnesses and disabilities will complicate issues of adjustment and adaptation.

  Primarily, exposure to critical incidents for people with disabilities may be "trigger events" that can exacerbate current medical conditions and cause some people to relapse; thus, there are unique characteristics of facilitating crisis interventions for people with disabilities.

- ***Regardless of disability, survivors of previous traumatic events may be retraumatized by critical incidents.*** When people who have existing mental or physical disabilities experience a traumatic event, the crisis event may

combine with these other issues to produce a synergistic effect, which may intensify the person's response to the extraordinary stressful and traumatic event.[24]

Extraordinary Stressful or Traumatic Events and PTS

Emotional stress is a part of everyday life. Most of us attempt to maintain a balance between healthy and unhealthy stress, which have four primary sources, from one's:[25]

- **Ecological environment**
- **Family/social situations**
- **Physiological level of health and functioning**
- **Cognitions and thought patterns**

When individuals do not cope well with the cumulative primary life stressors and "daily hassles," then chronic stress can occur. An unhealthy response to dealing with chronic stress may result in chemical dependency, depression, and even suicide.[26] Mind–body research (i.e., physiological and psychometric measures combined) has also demonstrated that when chronic stress has not been dealt with effectively, our internal biological functioning is frequently affected.[21]

It is important for rehabilitation counseling professionals to make the distinction between everyday emotional stress and extraordinary stressful or traumatic events that may result in more long-term clinical symptoms, such as those associated with PTS. Traumatic and enormously painful events vary in their psychological and emotional impact. While not all painful events are traumatic for the individual, some survivors become physically, psychologically, or emotionally overwhelmed and may require assistance from a professional counselor or peer-support group.

PTS differs from acute (nontrauma- induced) and chronic stress in that it is provoked by events that occur outside the normal range of most human experience and may be totally disabling to the person physiologically as well as psychologically. **The DSM-IV**[19] **indicates that PTS occurs as the result of exposure to a traumatic event in which the person (a) experienced, witnessed, or was confronted with an event that involved actual or threatened death or serious injury; and (b) has responded with intense feelings of fear, helplessness, or horror.** Individuals have difficulty cognitively processing and emotionally responding to the overwhelming event. Soon the event becomes an **overpowering sensory experience as the person continues to attempt to make "ordinary" sense from an extraordinary event.**

It is suspected that there may be many other groups of people that do not meet the criteria for PTS (e.g., adult children of alcoholics, victims of racism, victims of sexual harassment), **but who do exhibit evidence of acute stress or PTS.** Ivey and Ivey[8] propose a Developmental Counseling and Therapy (DCT) model that offers an approach using the PTS classification system of the DSM-IV. These authors advocate expanding the view of trauma by reframing the client's severe distress, or acute stress episodes, as a response to their environment and developmental history. They further propose that "In the framework of DCT, trauma can be extended to include repeated sexual or racial harassment, a physical beating as a result of homophobia, poverty, and repeated issues of discrimination for reason of physical disability or challenge."[8(p.343)] For example, it has been estimated that 80% of people exhibiting symptoms of PTS are survivors of rape, physical injury, or other life-threatening traumatic events.[27]

The prevalence of PTS symptomatology in people with cancer and other life-threatening illnesses has lead to a new direction in PTS research. The psychological sequelae of cancer survivors have focused almost exclusively on feelings of anxiety, anger, or depression. However, a growing body of research suggests that people with acquired life-threatening illnesses exhibit intrusive, persistent, and traumatic thoughts related to their disease.[23] **Overall, it appears that the diagnostic category of PTS has too narrow an assessment focus and does not give full environmental considerations for persons with chronic illnesses and mental, emotional, or physical disabilities.**[8]

Ecological Environmental Considerations:

It is critical to understand the impact the environment has on the psychosocial functioning of people with PTS. The "person-in-the-environment" focus has long been a theoretical precept within the rehabilitation counseling literature.[28] **Many authors suggest that the use of the word "disorder," as in PTSD, is misleading because it tends to focus on issues of stress within the person rather than recognizing that the environment may be a precipitating factor.**[8,29,30] More recently, Hershenson[31] proposed a systemic, ecological model that rehabilitation counselors can use to view the rehabilitation process and choose appropriate interventions. I include this model because of its application to the adjustment and adaptation process in coping with extraordinary stressful and traumatic events.

Hershenson proposes the examination of systems and subsystems that comprise:

- Values and attitudes
- Behavioral expectations and skill demands of the person
- Potential resources and supports
- Presenting physical and attitudinal barriers
- Opportunities and reinforcers that the system has to offer

It is critical that rehabilitation counselors be mindful of how all of these systems and subsystems interact and affect the individual before choosing any interventions that might be used in a crisis-demand situation.

Psychosocial Response of Survivors

In this section, a discussion of the psychosocial response to traumatic events will be presented as it relates to: (a) survivors (b) family members, (c) the sociocultural community environment, and (e) rehabilitation counseling professionals.

Psychosocial Stages of Adjustment and Adaptation:

Aiding in the synthesis of grief and loss experiences appears to be at the heart of serving people who have experienced extraordinary stressful or traumatic events. Individuals who are confronted with such adversity experience a multitude of losses. For example, some individuals who are survivors of violent crimes may feel the loss of a sense of fairness or justice with the legal system.[32] Those who experience life-threatening illnesses may feel a loss of their faith in God or a higher power.[33] People who have acquired a chronic illness or disability may feel the loss of their future as it relates to their vocation, emotional, social, or physical health, and many other life areas.[34]

The sense of loss and grief requires that the individual adapt and adjust for survival. The terms psychosocial adaptation and psychosocial adjustment often overlap, and the concepts are often indistinguishable in the literature.[7] **Generally, psychosocial adaptation is a dynamic process, a subjective experience that involves both internal and external factors. Adaptation describes the degree to which the person functions successfully physiologically, psychologically, and socially after a traumatic event, such as an acquired disability. The concept of adjustment typically refers to a specific phase of experiences or psychosocial reactions to the chronic or disabling condition and relates to how the individual and others perceive the actual loss or trauma sustained.**

There are a number of stage models offered in the literature regarding psychosocial adaptation and adjustment to disability, trauma, crisis, grief, and loss.[14,29,32,35-37] These models emphasize that the prolonged course of treatment, often uncertain prognosis, constant intense psychological stress, limited daily functioning, and the psychological impact on family and friends all combine to create complications in adjustment and adaptation to extraordinary stressful and traumatic events. Stage models also make it clear that:

- There is no universal experience or response to chronic illness, trauma, or disability
- A state of final adjustment (sometimes referred to as resolution, acceptance, assimilation, or reintegration) is not always achieved by the individual

- **Based on the available clinical and empirical evidence, psychological recovery does not follow an orderly sequence of reaction phases. Thus, individuals may experience phases of adjustment on a continuum and may regress to an earlier phase, skip one or more phases, or may overlap with other phases.**[7]

Overall, it is suggested that each stage of adjustment:

- Requires different coping patterns
- May be both maladaptive and adaptive
- Has a variety of emotional triggers that hinder the survivor's ability to adapt to the experience of trauma, loss, or disability

Common Phases in Reaction to Extraordinary Stressful or Traumatic Events:

The following section briefly describes common phases of reactions associated with psychosocial adaptation to chronic illness, trauma, and disability as offered by Livneh and Antonak's research.[7] These authors hypothesize and suggest that as the person completes or gains closure within a particular phase, that they reach some level of meaning, emotional growth, and understanding regarding their disability which will help them transition into the next phase.

Shock

The individual's initial emergency reaction to the onset of sudden and severe trauma. Shock is characterized by psychic numbness, overwhelming physiological experience, and cognitive disorganization.

Anxiety

Viewed as a panic reaction, anxiety is marked by confused thinking, cognitive flooding, and numerous physiological correlates.

Denial

Denial is one of the more problematic reactions because its subtle, often conflicting aspects make it difficult to verify. Denial is marked by defensiveness, minimizing, or unrealistic thinking.

Depression

Depression is a reactive response as a result of the trauma; the degree of depression depends upon family history, predisability trauma, reaction to the stressors involved with the trauma, and biological or neurochemical changes attributable to the disability. **People who are depressed typically report feelings of helplessness, hopelessness, isolation, and despair.**

Internalized Anger

This emotion is perceived to be the person's self-directed resentment and bitterness, **often associated with feelings of self-blame or guilt.** This reaction is often most evident in people who realize that the impairment is a chronic and disabling condition.

Externalized Hostility

This behavior may be the individual's attempt at retaliation and is marked by hostility directed at other people or objects, or aggressive or passive-aggressive acts.

Acknowledgment

This phase is regarded as the first indication that the person has a cognitive awareness of the losses that have occurred in his or her life. There is a cognitive reorganization toward self and the external environment. The individual begins to accept him/herself as a person with a permanent impairment, gains a new sense of self, and has the ability to reappraise life goals and seek new meanings.

Adjustment

Characterized as the theoretical or final phase of the adaptation process, the person who reaches this theoretical phase reestablishes self-worth, realizes the existence of remaining or newly discovered potentials, actively pursues and implements social and vocational goals, and successfully overcomes obstacles encountered in the pursuit of his or her goals.

The Family's Response:

Families of the twenty-first century are culturally and socially very different from those of any other time and it seems that the stress in today's family unit is unparalleled by that of any other generation. Traditional family roles and values have changed, economic factors have required two household incomes, and the emotional antecedents and aftermath of "divorce-wars" have a significant impact on the family. Some statistics on divorce indicate that as many as 60% of youth will spend a portion of childhood or adolescence in a single-parent environment.[38] These factors, when combined with extraordinary stressful and traumatic events, make it increasingly difficult to use family members as a support mechanism. **However, the family as a social institution remains the most important factor influencing how well survivors of trauma or disability adapt. The family's resources (e.g., financial status, emotional and other support networks) have a significant impact on how individuals within the family survive adversity;[26] yet, the best resource that family members have is each other.** The marital relationship is key, and is considered one of the most important elements for surviving traumatic events within the family system.[39] Marital distress tends to evoke, maintain, and exacerbate the family's response to trauma. If the marital relationship is not dealt with in a therapeutic manner, both partners often have a decreased ability to cope with the acute and long-term emotional effects of trauma.

Ideally, the family should provide each member with protection, love, security, identity, self-esteem, and a value system that emphasizes the positive qualities of life.[40] Generally, families cope with extraordinary stressful and traumatic events in the same way and with the same success as past life crises.[41] Some families that have experienced trauma and disability report that they have coped quite well with little or no outside intervention. Protective factors that can reduce stress and traumatic responses included adequate rule setting and structure, family cohesion, lower parental conflicts, open communication, warmth toward the child, and being patient in parenting interactions.[42]

Dysfunctional family behaviors are especially critical in the child's growth and development and can be the source of difficulties carried into adulthood. Feelings that are prevalent among dysfunctional families include anger, sadness, shame, and fear. Families that have not coped well with past crisis events tend to exhibit alcohol and substance abuse behaviors, physical violence, physical, emotional, and sexual abuse, emotional and physical neglect, separation, and divorce.[24,43,44] Children observe older siblings, as well as the adults within their family, as examples of how they should respond emotionally to stressful events and family crisis.[40] **Unhealthy coping responses such as not verbalizing feelings, long-term denial, or active avoidance of a crisis event will likely result in more severe problems later in life.[45] The family can be strengthened as family members learn to increase and encourage disclosure of feelings and emotions associated with the traumatic experience.** Parents must give permission openly for their children to grieve the traumatic experience by creating an environment of trust and support which encourages the children to verbalize their feelings and experiences. Overall, a more securely attached family and an increased level of social support can help successful adaptation on many levels. Further, rehabilitation counselors who specialize in substance abuse treatment as a co-existing disability with other trauma issues related to the family dynamic can help bring this system back into balance.

The Sociocultural Community's Response:

Recently, researchers have begun to examine the psychosocial responses of communities who have been exposed to violent and traumatic events. Individuals within communities can experience psychological trauma through indirect knowledge of, or exposure to a crisis event.[46] In my experience counseling people in communities where school violence and natural disasters (i.e., hurricanes, tornadoes) have occurred, it is evident that the community-at-large is a secondary survivor of crisis events. The phenomenon of "vicarious victimization" describes this experience, which is associated with seven specific factors that increase its likelihood.[17] These factors are:

- **A realistic threat of death to all members of the community**
- **Extraordinary carnage**
- **Strong community affiliation**
- **Witnessing of the event by community members**
- **Symbolic significance of victims to the community (i.e., children)**
- **Need for numerous rescue workers**
- **Significant media attention**

Generally, qualitative research suggests that PTS as a result of extraordinary stressful or traumatic events has psychological consequences that are more far-reaching for the community as a whole than was once thought.

Social and cultural factors such as gender, ethnicity, race, disability, socioeconomic status, level of acculturation, and urban vs. rural culture also have an impact on how emotions are expressed collectively by a community. Knowledge of the person's cultural and social norms for expressing emotion during trauma, grief, death, and dying is critical. For example, in the Amish culture, there is a calm acceptance of trauma, grief, death, and dying, which is marked by a high level of support given to bereaved family members. In New Orleans, some African Americans engage in funeral rituals that include marching or parading through the streets with music and dancing. Mexican Americans, because of language, cultural, and socioeconomic barriers, are often cut off from traditional western professional medical and mental health services, especially in rural areas.[47] Thus, they are more dependent on the family or folk medicine to assist in the emotional healing process. Counselors need to respond to the client by recognizing the person's individuality (e.g., race, ethnicity, gender) and common coping abilities (e.g., family, socioeconomic, and community support) through a holistic multicultural approach.[48,49]

Certain segments of the community, such as children, older persons, or different cultural groups that may have feelings of being victimized, are particularly vulnerable to the psychosocial impact of traumatic events. For example, research indicates that people who live in rural settings felt safer in their homes than persons, especially older adults, who live in urban settings.[50] When violent crime occurs in rural areas, the person's feeling of emotional security is upset and the community becomes out of balance. When violent crime occurs in urban areas, particularly, people who work in institutions such as schools, churches, or social clubs may exhibit symptoms of PTS that include depression, fear, sleeping or eating disorders, or substance abuse behaviors. These feelings may be intensified and exacerbated by extensive media coverage of the community's crisis event, lengthy police investigations, or civil litigation.

Community Interventions

Most extraordinary stressful and traumatic events do not occur in isolation. Rather, critical incidents act as "shock waves" that affect the community as a whole, regardless of whether the critical incident stems from a natural disaster, school shooting, or a neighborhood shooting. There is much that community leaders can do to offer social support and increase the therapeutic environment during times of a community crisis. **However, interventions require building relationships within the community through police, mental health professionals, schools, teachers, and administrators, as well as spiritual and religious groups.**[51] An organized effort among these institutions can help develop a sense of community empowerment.[52] For example, promoting commendations and awards to rescue workers, counselors, and other volunteers who have been part of the community crisis response team is an important part of the healing process. Public leaders (i.e., city, state, federal officials) also have a powerful influence in the community. These leaders should be encouraged to express their own grief which will in a sense, signal permission for others to grieve the community's loss. [53]

When others outside a region recognize and acknowledge community members grief, then the affected community will generally feel a sense of support and connection to the outside world. This support is necessary in the healing process. For example, after the Westside Middle School shootings that took place in Jonesboro, Arkansas, children from other middle schools around the nation sent cards, letters, and posters to express their deepest sympathy for the loss sustained by the Westside students. Miller [54] emphasizes that a support network of outside mental health consultants and other service providers also serves an important function during community disasters. **They can assist the affected community in developing a plan for education and prevention which will promote safety and security. Planning actions such as these and instituting them can help people within the community feel that they can gain some control over their lives again.** As a member of the Westside crisis response team, the present author experienced first-hand how outside help could provide additional support, energy, and assistance in the crisis debriefings with the large numbers of students, teachers, and parents who were affected by this crisis event. It may be a natural response for members of a community in crisis to feel that no one outside their community can understand or relate to their tragedy. However, communities in crisis should not hesitate to ask for outside assistance because there are many talented individuals who can assist in the recovery process.

Rehabilitation counselors are uniquely qualified to assist as members of a crisis response team due to their academic training with issues related to loss and grief, which are integral to the process of psychosocial adaptation and adjustment to chronic illness, disability, and life after a crisis event. Through counseling and case coordination activities, the rehabilitation professional can utilize community resources to assist with the survivor's physical, emotional, psychological, social, vocational, and independent functioning needs.

The Counselor's Response:

Recent and accumulating research related to trauma and disability,[3,55] along with the applied experiences of mental health and rehabilitation counseling professionals[56] indicate that there is a natural secondary traumatic stress response that is associated with providing services to individuals and groups who are directly and indirectly affected by traumatic events. This response is known as the phenomenon of empathy fatigue[10,19] or compassion fatigue.[3,57] ***Empathy fatigue* is the grief reaction, or the psychological, emotional, and physical exhaustion that occurs during helping interactions. Dealing with another person's traumatic experience has a definite impact on the professional's behavior and personal life.[58]** Many rehabilitation professionals who work with survivors of trauma and those with chronic life-threatening illness and disability are frequently exposed to their client's life story and experiences. Counseling professionals must be empathically available to individuals or family members; in fact, the Code of Professional Ethics for Rehabilitation Counselors[59] emphasizes that rehabilitation counselors are compelled by ethical obligation to place their clients' needs and interests above their own.

The nature of STS has been illustrated by Figley[3] in the traumatology and psychology literature. He suggests that STS is equivalent to PTS. STS is the natural emotional and physiological response resulting from learning about, or knowing about, a traumatizing event that has been experienced by another person. In other words, **the professional helper can experience similar feelings without actually being physically harmed or threatened with harm.** The DSM-IV[20] notes specific characteristics and features of PTSD, but the underlying premise is that people can be traumatized either directly or indirectly as either primary or secondary survivors.

Counselors or caregivers who may not be aware of this parallel process or the experience of countertransference may be at risk for increased levels of anxiety, depression, or substance abuse behaviors. Counseling professionals who are just beginning their career have little preparation for dealing with people in trauma. Studies have shown that younger, less experienced counselors report higher levels of STS than those who are more seasoned professionals.[60,61] This is primarily because the experienced professional has learned different ways of coping with his or her job and working more efficiently. When the cumulative effects of STS go unrecognized, or the individual or organization has little capacity for dealing with a traumatic event, this may lead to a secondary stress reaction and increased levels of emotional, mental, and physical exhaustion.

Adaptive Coping, Prevention, and Intervention Strategies

Survivors of extraordinary stressful or traumatic events typically spend a lot of time and energy avoiding the feelings, thoughts, and activities that are associated with the critical event. This is a normal response. Some avoidance of past crisis events may be an important coping strategy. However, too much emotional avoidance or suppression may result in numbness or dissociation from the cognitive and emotional experience of past stressful events.[62] **Thus, dealing with the psychological and emotional impact of a critical incident early on will ultimately benefit individuals, family members, organizations, and the community in adaptation and healing.** The following strategies are recommendations which can be given to survivors to initiate or continue the adjustment process to extraordinary stressful or traumatic events.

Adaptive Coping Strategies for Survivors:

1. Allow time for the transition back into a day-to-day routine, such as school or work.
2. Identify friends and family members who may be physically, psychologically, or emotionally at risk.
3. Be familiar with the resources available in your community that will support your recovery.
4. Support your peers and allow them to talk about their loss and reinforce their positive steps toward recovery.
5. Focus on the routine things that you are able to do, as well as some positive things that you have done in the past.
6. Establish ongoing support and contacts with friends and family members.
7. Be mindful that the most important resource you have is one another—the other individuals that have been through the same or a similar experience.

Strategies for Coworkers, Friends, and Family to Support the Survivor:

1. Be an active listener for the survivor but do not get "hooked" into the role of counselor.
2. Identify when the survivor is emotionally overwhelmed and suggest professional help.
3. As difficult as it may be for you, allow and invite the survivor to talk about his or her feelings of loss or fear of future critical events.
4. Establish regular contact with the survivor to ensure that he or she is safe and has adequate emotional and social support.

Strategies for Organizations and Employers to Support the Survivor:

1. After the survivor has been through a critical incident, it is likely that the person will have a difficult time focusing on job performance. Allow the survivor time to transition back to the day-to-day work routine. Take a "time-out" from your regular structure for an "emotional check-in" with the survivor. You may want to begin the work day or a meeting by giving permission and allowing the survivor to ventilate feelings concerning a recent past extraordinary stressful experience. Verbalizing thoughts and emotions has therapeutic benefits.
2. Be sensitive to the emotional needs of the survivor during work. While you are not (and do not need to be) a professional helper, you can offer to be a good listener.
3. Familiarize yourself with and promote educational or wellness-type resources for survivors. Be aware of employees who may be at risk for additional emotional or psychological stress.

4 **Be aware that you may be experiencing some stress-related symptoms associated with the emotional aftershocks. Also, be mindful that secondary stress is a natural artifact of just being around or overhearing the survivor's stories of extraordinary stressful experiences.**

5 **Emphasize the survivor's strengths by reinforcing positive aspects of current functioning or productivity level.**

NOVA Model of Group Crisis Intervention

The National Organization for Victim Assistance (NOVA) offers an excellent model for group crisis intervention.[32] This model uses a similar protocol to that of CISD models and is composed of three phases of intervention which can typically be accomplished in one 90-minute session. **The strategies and approaches used to facilitate group debriefings allow crisis responders to work with large groups of both primary and secondary survivors.** NOVA has adopted the term "group crisis intervention" rather than "group debriefing" because the term "debriefing" is often confused with models used with military and law enforcement personnel, which may create confusion or inhibit participation among civilian survivors of traumatic incidents. The NOVA model differs from typical debriefings and therapeutic or support groups that are ongoing in nature because this (and other) crisis intervention groups are usually formed immediately after a critical event.

Group crisis interventions often take place at or near the site of the critical incident. Strategies in this model allow group facilitators to consider group size as well as sociocultural aspects of the group or organization. Peer groups should ultimately be arranged in separate sessions with the survivors who were closest to the epicenter. Those groups who were indirectly affected by the critical event, such as counselors or trauma rescue or crisis response personnel should be debriefed in a separate group. Timing of the group crisis intervention is also critical, as it relates to a crisis event (e.g., several hours postcrisis, day after, one week later).

Safety and Security:

The first phase of the model, *Safety and Security*, usually begins with introductions of the group facilitator(s), providing parameters for building an environment based on trust, safety, confidentiality, and personal disclosure. The goal of this phase is to provide a safe environment for survivors to release intense emotions after a traumatic event.

Ventilation and Validation:

The second phase of the model, Ventilation and Validation, allows survivors to ventilate and review physical, emotional, and sensory experiences they associated with the critical incident. Some key questions that the group facilitator(s) may use during this phase include:

- **Where were you when this incident happened?**
- **Who were you with?**
- **What did you see, hear, smell?**
- **What did you do next?**
- **How did you react at the time?**

This phase of intervention provides an opportunity for survivors in the group to become aware that others have had similar experiences. This is also an opportunity to educate the survivors on common emotional reactions to extraordinary stressful and traumatic events, reinforcing the belief that they are not "going crazy" and that other people in the group have similar feelings and emotions. During this phase, survivors should be provided with factual information regarding the traumatic event that has taken place to dispel any misinformation and counter any myths or rumors. A second set of questions that would be beneficial in this phase includes:

- **Since the time of the event, what are some of the memories that stand out for you?**
- **What has happened in the last 48 hours?**
- **How has this event affected your life?**

Prediction and Preparation:

The last phase, *Prediction and Preparation*, should be a time for group members to cultivate seeds of hope for the future. Goals for this phase are for survivors to prepare for future emotions and identify any critical life areas that would hinder their recovery. This is also a time for survivors to identify resources and supports that will facilitate coping and healing. The third series of questions that the group facilitators may use includes:

- **After all that you have been through, what do you think will happen in the next few days or weeks?**
- **Do you think that your family, friends, and community will continue to be affected?**
- **Do you have any concerns about what will happen next?**

Conclusion

Extraordinary stressful and traumatic events such as fires, floods, hurricanes, or school shootings have a significant impact on survivors' physical, emotional, psychological, social, spiritual, and financial well-being. Regardless of how close we may be to the epicenter of such an event, it is quite normal and expected that emotional aftershocks can affect survivors weeks and even months after experiencing the critical incident. Thus, it is important and necessary to deal with interventions early- on and be mindful of how to cope with possible future emotional triggers.

Presently, the literature does not specifically address the role and function of the rehabilitation counselor as part of a crisis response team. However, I have personally worked along side other rehabilitation counselors during critical incident stress debriefings and have found these professionals to be well-trained, skilled, and competent in dealing with the psychosocial adjustment needs of persons in crisis. Historically, rehabilitation professionals have functioned in the roles of case manager, counselor, and consultant for persons with acquired chronic illness and disability. Indeed, rehabilitation professionals "wear many hats" and have a breadth of knowledge and skills to deal with the individual's physical, emotional, psychological, social, vocational, and independent functioning needs. Accordingly, persons directly affected by physical and emotional trauma will likely become part of the "disability community" and will require ongoing services and commitments from many other helping professionals. Thus, by virtue of the rehabilitation counselor's academic training and the diversity of job settings, these professionals can provide both direct services (i.e., mental health and substance abuse counseling), as well as acting as the "case coordinator" to directly link the person with a variety of other community resources.

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Questions Based On This Lesson

To earn CE credits, answer the following questions on your quiz response form.

21. It is important to recognize the psychosocial needs of "secondary survivors" that are involved in critical incidents because secondary survivors:

A. Are more prone to suicidal ideation than primary survivors following traumatic events.

B. Can be at-risk for the same symptoms related to posttraumatic stress as the primary survivors, or persons most directly affected by the traumatic event.

C. Can serve as peer counselors directly after a traumatic event because they are usually less emotionally affected than primary survivors.

D. Tend to overreact to traumatic events more easily than primary survivors, therefore, they may require more intensive counseling.

22. Which of the following statements best describes stages of adjustment and adaptation to chronic illness and disability?

A. Based on clinical and empirical evidence, the psychosocial recovery process appears to follow a linear pattern and most individuals experience all phases of adjustment along the same continuum.

B. It has been empirically validated that all persons with chronic illnesses and disabilities tend to experience the stages of adaptation in the same order.

C. Individuals with chronic illnesses and disabilities may experience similar phases of adjustment, however, some may regress to an earlier phase while others may skip a phase and return later.

D. All persons with chronic illnesses and disabilities reach a phase referred to as resolution or acceptance, and then reintegrate into society at some point in treatment.

23. The primary purpose of involving survivors in critical incident stress debriefings is to:

A. Decrease the risk of the survivor acquiring symptoms associated with posttraumatic stress.

B. Provide education and information to the survivors so that they won't need further counseling.

C. Eliminate the need for a defusing.

D. Engage the survivors in group psychotherapy for purposes of maximum recovery and adjustment.

24. The NOVA Model of Group Crisis Intervention uses a protocol involving three stages of debriefing. Which statement best describes the purpose and function of the "Ventilation and Validation" phase?

A. The Ventilation and Validation phase creates a good initial safe environment for survivors to release intense emotions after a traumatic event.

B. The Ventilation and Validation phase encourages the identification of future emotional triggers and other critical life areas needed for recovery.

C. The Ventilation and Validation phase promotes a problem-solving or solution-focused approach.

D. The Ventilation and Validation phase provides an opportunity for survivors to share and discuss emotional reactions that others in the group have experienced.

Directions in Rehabilitation Counseling

Volume 12 Lesson 7

Problem Gambling: The Addiction of the New Millennium

Brian T. McMahon, PhD, CRC, NCC, CCM,
and Carolyn E. Danczyk-Hawley, MS, CRC

Dr. McMahon is Professor and Chair, and Ms. Danczyk-Hawley is Project Coordinator, Department of Rehabilitation Counseling, School of Allied Health Professions, Medical College of Virginia Campus, Virginia Commonwealth University, Richmond, VA.

Introduction

A variety of terms have been used in gambling research literature to refer to the difficulties caused by an individual's gambling. Pathological gambling, a disease first recognized by the American Psychiatric Association, is defined as "a recurrent gambling behavior that disrupts all aspects of the gambler's life."[1] The *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM-IV),[1] suggests that persons meeting 5 or more of 10 criteria should be classified and treated as pathological gamblers (see Table 1). Problem gambling refers to the behavior of individuals who meet fewer than 5 of the DSM-IV criteria and includes patterns of gambling behavior that compromise, disrupt, or damage personal, family, or vocational pursuits.

The objectives of this lesson are to provide the counselor with an understanding of the worldwide proliferation of legalized gambling, the nature and scope of problem and pathological gambling, and specific considerations in the diagnosis, treatment, and prevention of problem gambling. The intent is to make the counselor aware of problem gambling as an economic, social, occupational, and clinical phenomenon, which may coexist with other behavior disorders. This lesson also discusses resources for evaluation, treatment, and ongoing education regarding problem gambling.

Table I
DSM-IV CRITERIA FOR A DIAGNOSIS OF PATHOLOGICAL GAMBLING

1. Preoccupation with gambling (e.g., preoccupation with reliving past gambling experiences, handicapping or planning the next venture, or thinking of ways to get money with which to gamble)
2. A need to gamble with increasing amounts of money in order to achieve the desired excitement
3. Repeated unsuccessful efforts to control, cut back, or stop gambling
4. Restlessness or irritability when attempting to cut down or stop gambling
5. Gambling as a way of escaping from problems or of relieving a dysphoric mood (e.g., feelings of helplessness, guilt, anxiety, depression)
6. Tendency, after loss of money through gambling, to return another day to get even ("chasing" one's losses)
7. Lies to family members, therapist, or others to conceal the extent of involvement with gambling
8. Commission of illegal acts such as forgery, fraud, theft, or embezzlement to finance gambling
9. Jeopardizing or loss of a significant relationship, job, or educational or career opportunity because of gambling
10. Reliance on others to provide money to relieve a desperate financial situation caused by gambling

The U.S. government has made a significant investment in the intensive study of gambling in recent years,[2,3] and this research constitutes the basis for this lesson. The authors of these studies consolidated and critically reviewed all earlier research that was available. **Reading these studies in detail will enable counselors quickly to become familiar with the best and latest information in this relatively immature field, in which a coherent program of scientific inquiry is just beginning to emerge.**

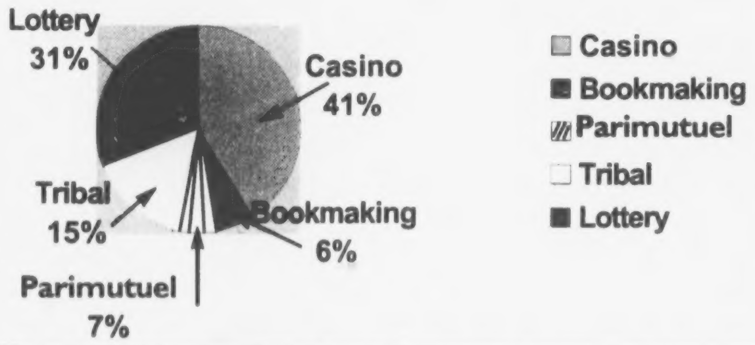
The Proliferation of Legalized Gambling

According to the U.S. General Accounting Office,[2] approximately 86% of American adults have gambled sometime in their lives, and 63% report having gambled in the previous year. More people are gambling than ever before,[2] and they are wagering more. In 1997, Americans collectively wagered more than $551 billion. The estimated profits from legalized gambling totaled about $54.3 billion in 1998 (see Figure 1). In 1999, 48 of the 50 states had some form of legalized gambling; only Utah and Hawaii did not. Casino-style games are available in 21 states, and 37 states have lotteries. One form of gambling (i.e., state and regional lotteries) is one of the major for-profit businesses actually owned by the government.

The expansion of gambling has taken many forms, including state lotteries, convenience gambling, land-based casinos, riverboat casinos, Native American tribal gambling, parimutuel wagering, simulcasting, account wagering, and sports wagering. Marketing, public policy, and regulation, or the lack thereof, all play important roles in this expansion. With the advent of new gambling technologies (especially Internet-based technologies), pathological gambling is likely to become even more widespread, and there is increased concern about the impact of both problem and pathological gambling.

Given this situation, a national response to this phenomenon was inevitable. In 1997, the National Gambling Impact Study Commission[3] was charged with conducting a comprehensive study of the social and economic implications of gambling in the United States. Spanning three years and costing $8 million, the study reflected the varied and conflicting views of commission members representing every conceivable constituency. It covered the expansion of gambling, regulation and the role of government, clinical manifestations of gambling behavior, Internet gambling, Native American tribal gambling, and the impact of gambling on communities. **In this study, pathological gambling was defined as a chronic, progressive failure to resist impulses to gamble. In the United States alone, pathological gambling in this sense affects 1.8 million adults and 1.1 million adolescents in any given**

Figure 1
SOURCES OF $54.3 BILLION IN 1998 GAMBLING INDUSTRY GROSS REVENUE



US General Accounting Office. *Impact of Gambling.* Washington, DC: Author; 2000:5. US General Accounting Office publication 66D-00-78.

year. Elderly people, poor people, persons in sensitive occupations (i.e., persons working within the gambling industry) and people with disabilities may have disproportionately higher rates of pathological gambling, but this has not been verified. Pathological gamblers are believed to be more likely to commit crimes, run up large debts, damage relationships with family and friends, engage in domestic violence and child abuse, and commit suicide. However, there is no conclusive evidence on whether or not gambling actually causes increased social problems.[2] Tracking systems generally do not collect data on the causes of these incidents, and it is difficult to isolate the contribution of pathological gambling to these problems because such gambling is often accompanied by other behavior disorders.

Assessment

What is available today in the way of assessment and treatment approaches for pathological or problem gamblers? **To some extent, one's assessment approach will be grounded in one's view about how disordered gambling behaviors are developed and maintained across the life span.** Scientifically speaking, however, the onset and development of pathological gambling remains somewhat of a mystery. **Pathological gambling has been variously described as an impulse disorder, an addiction, a behavioral response to environmental cues, and a manifestation of reward deficiency syndrome. Problem or pathological gambling often appears to occur with other impairments such as substance abuse, mood disorders, and personality disorders. The sooner one begins to gamble, the more likely one he or she is to become a pathological gambler.** Twin studies and recent neuroscience studies suggest that familial factors and the social environment may influence pathological gambling. An assortment of theorized gambling typologies are also available. These include action vs. escape seekers, levels of gambling (0–3), stage theories and other perspectives. The taxonomy from the Committee on Social and Economic Impact of Pathological Gambling study[4] is helpful; a modified version of this taxonomy appears in Table 2.

Screening and assessment tools for pathological gambling include psychosocial history, psychometric measures, and biochemical indicators. Yet none of these is as important as a thorough understanding of established diagnostic criteria. As opposed to less excessive forms of gambling, pathological gambling is rather well understood. Clinicians and researchers rely heavily upon the diagnostic criteria listed in the DSM-IV (see Table 1).[1] **In diagnosing pathological gambling, it is important to distinguish it from:**

- **Social gambling, which occurs with friends and lasts for a limited period of time with predetermined acceptable losses.**
- **Professional gambling, in which risks are limited and discipline is central.**
- **Manic episodes, in which gambling exemplifies the loss of judgment characteristic of mania in a person who does not gamble at other times.**

Table 2
TYPES OF GAMBLING BEHAVIOR

Level 3 Gambling—Pathological:
Mental disorder characterized by a continuous or periodic loss of control over gambling,a preoccupation with gambling and with obtaining money with which to gamble,irrational thinking,and a continuation of the behavior despite adverse consequences.Meets at least 5 of the 10 DSM-IV criteria for compulsive gambling; referred to as compulsive gambling by lay persons or in the self-help treatment community.

Level 2 Gambling—Problem:
Gambling behavior that results in harmful effects to the gambler,family,significant others,friends,coworkers,etc.Meets fewer than 5 of the 10 DSM-IV criteria.

Problematic,Excessive,or Intemperate Gambling:
Refers to any amount of time or money spent gambling that exceeds an arbitrarily defined acceptable level.

Level 1 Gambling—Social,Recreational:
Gambling behavior for entertainment or social purposes with no harmful effects.

Level 0 Gambling:
No gambling at all.

Source: Modified from Committee on the Social and Economic Impact of Pathological Gambling. *Pathological Gambling: A Critical Review*. Washington, DC: National Academy Press: 1999.20–21.

Pathological gambling has other associated features, though they do not rise to the level of diagnostic criteria. Affected individuals are described as competitive, energetic, restless, generous to the point of extravagance, work addicted, superstitious, overconfident, controlling, and power-seeking. **They are said to lack insight and believe that money is both the cause and solution to all problems.** Pathological gambling is frequently found to coexist with stress-related medical problems, mood disorders, attention-deficit/hyperactivity disorder, substance abuse, and specific personality disorders (antisocial, narcissistic, and borderline). Of the individuals in treatment for pathological gambling, approximately 20% are reported to have attempted suicide.

Although the definition of pathological gambling is widely accepted, there is no consensus as to whether it should be classified as a dependent condition (an addiction) or as a disorder of impulse control. For the time being, it is classified as the latter, which, among other things, makes reimbursement for treatment of the condition difficult. The validity of treating pathological gambling as a primary disorder independent of other mental illness is the subject of considerable debate.

Diagnosis and assessment are much more "fuzzy" with respect to other levels of gambling severity. Not all gamblers are excessive in their behavior; not all excessive gamblers are compulsive or pathological in their behavior; and not all pathological gamblers are impaired in every life area. Cases of problem gambling, in which individuals meet fewer than 5 of the criteria for a diagnosis of pathological gambling, may involve "in-transition" gamblers who are moving either toward or away from pathological states.[5] They are not necessarily in an earlier stage of the disorder, because there is no empirical evidence that actual progression of the illness is linear.[6] In fact, "in-transition" gamblers may, alternatively, become pathological, move toward recovery with or without treatment, or languish in this state indefinitely.

Treatment Options

There are but a handful of controlled outcome studies that address the treatment of pathological gambling. The lack of rigorous research is compounded by the lack of funding, which the federal government has only recently begun to address. Two decades of substance abuse treatment have demonstrated that some treatment is better than none, but at this point in time there is no similar validation of the incremental value of treatment for pathological gambling. Limited research suggests that pathological gamblers who seek treatment generally improve, but the lack of quality research in this field renders this a suggestion rather than a conclusion.

With respect to treatment, the impediments to self-referral, outreach, recruitment, and retention are simply not known. The extent to which treatment needs to be customized for women, adolescents, and persons of varying cultural groups is also not known. **It is reasonable to expect that treatment should vary as a function of other patient characteristics as well, including the level of gambling involvement, etiology of the behavior, and presence or absence of coexisting disabilities. Available treatment options include participation in Gamblers Anonymous, harm reduction, motivational enhancement interviewing, pharmacotherapy, aversive therapy, cognitive-behavioral therapy, and contingency management.** In addition, similar to other addictive processes such as alcohol use, natural recovery without any treatment intervention (i.e., spontaneous recovery) has been noted to occur among problem and pathological gamblers. However, in the absence of comprehensive assessment tools, criteria to maximize the likelihood of placement into appropriate treatment settings, and a system of case management to guide patients through a continuum of available services, we are a long way from being able to match patients with effective treatments. Lack of insurance coverage, stigmatization, and/or the unavailability of treatment in most communities likely complicate the process of seeking treatments.

Given the state of the art of treatment validation for problem gambling, considerable controversy exists over what knowledge, skills, and expertise are required of counselors seeking to provide treatment for problem or pathological gamblers. No experienced counselor would be surprised to learn that a certification process exists; it is managed by the National Council on Problem Gambling. The requirements for National Gambling Counselor Certification include:

- 300 (contact) hours of counselor education
- 60 (contact) hours of gambling specific training
- A supervised counseling internship
- 2,000 hours of supervised experience with gambling clients and their families

Recommendations for Government Action

The NGSIC[3] recommends that states and other government entities implement a number of measures to address the phenomenon of problem and pathological gambling before lotteries, or any other form of legalized gambling, be allowed to operate or to continue to operate. Such requirements should be specified in state statutes as applying to state-run lotteries and should also be specified and made applicable for inclusion in tribal government law and tribal-state compacts.

First, the NGSIC recommends that all relevant governmental gambling regulatory agencies require, as a condition of any gambling facility's license to operate, that each applicant:

1. Adopt a clear mission statement as to applicant's policy on problem and pathological gambling.
2. Appoint a high-ranking executive to execute and provide ongoing oversight of the corporate mission statement on problem and pathological gambling.
3. Contract with a state-recognized gambling treatment professional to train management and staff to develop strategies for recognizing and addressing customers whose gambling behavior suggests they may be experiencing serious to severe difficulties.
4. Refuse service to any customer, under a state "hold harmless" statute, whose gambling behavior convincingly exhibits indications of a gambling disorder.
5. Provide, to any customer to whom service has been refused (as described above), written information that includes a state-approved list of professional gambling treatment programs and state-recognized self-help groups.
6. Provide insurance that makes available medical treatment for problem or pathological gambling for facility employees.

In addition, the NGSIC suggests that each state and tribal government enact, if it has not already done so, a gambling privilege tax, assessment, or other contribution on all gambling operations within its boundaries, based upon the gambling revenues of each operation. A sufficient portion of such monies should be used to create a dedicated fund for the development and ongoing support of problem-gambling-specific research, prevention, education, and treatment programs. The funding dedicated for these purposes should be sufficient to implement the following goals:

1. **To undertake biennial research by a nonpartisan firm experienced in problem gambling research to estimate the prevalence of problem and pathological gambling among the general adult population. Specific focus on major subpopulations including youth, women, elderly, and minority group gamblers should also be included, as well as an estimate of prevalence among patrons at gambling facilities or outlets in each form of gambling.**
2. **To initiate public awareness, education, and prevention programs aimed at vulnerable populations. One purpose of such programs will be to intercept the progression of many problem gamblers to pathological states.**
3. **To identify and maintain a list of gambling treatment services available from licensed or state-recognized professional providers, as well as the presence of state-recognized self-help groups.**
4. **To establish a demographic profile for treatment recipients and services provided, as state and federal laws permit; to develop a treatment outcome mechanism that will compile data on the efficacy of varying treatment methods and services offered; and to determine whether sufficient professional treatment is available to meet the demands of persons in need.**

Pathological gambling is a recognized medical disorder, yet most insurance companies and managed care providers do not reimburse for treatment. The commission recommends to states that they mandate that private and public insurers and managed care providers identify successful treatment programs, educate participants about pathological gambling and treatment options, and cover the appropriate programs under their plans. In addition, each state-run or state-approved gambling operation should be required conspicuously to post and disseminate the telephone numbers of at least two state-approved providers of problem-gambling information, treatment, and referral support services. Each gambling facility must implement procedures to allow for voluntary self-exclusion, enabling gamblers to ban themselves from a gambling establishment for a specified period of time.

The NGSIC also endorses volunteer efforts by groups and associations across the United States to deal with problem gambling, especially efforts by practitioners to help problem gamblers. **These efforts should include strategically pooling resources and networking, drawing on the lists of recommendations these organizations have presented to the commission, and working to develop uniform methods of diagnosis.**

Conclusion

Over the past 25 years, the United States has been transformed from a nation in which legalized gambling was a limited and relatively rare phenomenon into a nation in which this activity is common and is growing more common. Today, the vast majority of Americans either gamble recreationally and experience few ill effects related to their gambling, or they choose not to gamble at all. Regrettably, some of them gamble in ways that harm themselves, their families, and their communities. Pathological gambling has been recognized and classified by the American Psychiatric Association, yet, many individuals still continue to suffer from a condition that is commonly undiagnosed and untreated.

References

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Questions Based On This Lesson

To earn CE credits,answer the following questions on your quiz response form.

25. **Studies have verified that which group(s) of people experience higher rates of pathalogical gambling than the general population?**

A. Elderly people

B. People with disabilities

C. Persons of lower socioeconomic status

D. All of the above

26. **Problem gambling is characterized as being which of the following?**

A. A Level O type of gambling

B. A Level 2 type of gambling

C. A Level 3 type of gambling

D. A Level 1 type of gambling

27. **Pathological gambling has frequently been found to coexist with:**

A. Substance abuse.

B. Personality disorders.

C. Mood-disorders.

D. All of the above

28. **In the DSM-IV, pathological gambling is classified as a(n):**

A. Disorder of impulse control.

B. Dependent condition.

C. Mood disorder.

D. Addiction.

Directions in Rehabilitation Counseling

Volume 12 Lesson 8

The Vocational Expert: Qualifying and Methodological Approaches to Earning-Capacity Evaluations

Rodney N. Isom, PhD

Dr. Isom is Assistant Professor in the Rehabilitation Counselor Training program, University of North Texas, Denton, TX. He has been in private practice since 1977 and has worked as a vocational expert since 1978.

Introduction

The Vocational Expert (VE) serves the disabled and the courts in many ways: VEs determine employability in social security settings; evaluate and write employment plans for individuals with disabilities for workers' compensation cases and Long-term Disability Insurance Carriers; prepare life care plans for catastrophically injured individuals; and recommend rehabilitation plans and evaluate employment status, earning capacity, and employability in personal injury cases. The VE's work in this arena is also known as forensic rehabilitation. *Black's Law Dictionary*[1] defines forensic rehabilitation as rehabilitation practices that take place in a legal setting. Because the forensic specialist operates in a unique context, the VE must understand the nature and requirements of the court to be effective. This lesson reviews laws, evaluation methods, and other considerations pertinent to the VE working in the personal-injury arena. This lesson should also help the reader understand the needs of the court for the best preparation of testimony and defense of the proposed opinion(s) of the expert. More importantly, the objective of this lesson is to provide the reader with the elements necessary to evaluate lost earning capacity and prepare a report on the subject which can be defended in court.

Damages

This section provides information on what types of damage wage loss and earning capacity loss represent. **There are several types of damages: hedonic, pain and suffering, punitive, and special damages. Hedonic damages relate to loss of pleasures in life.** Very few states allow hedonic damages at this time, although some states, such as Texas, still allow their presentation. **Pain and suffering is compensation for the actual pain and suffering, either physical or mental, caused by an injury. Punitive damages are awarded when the defendant has engaged in or exhibited deceptive, ruthless, or extremely irresponsible behaviors, or patterns of behavior**, and the court is punishing the defendant for their actions or lack of actions. **The VE is concerned only with special damages; liability, hedonic damages, pain and suffering, and punitive damages are not typical aspects of the VE's case.**

The VE is brought in to the case to determine how much the injury is worth. The VE is not used to prove liability, but rather to document the value of the damages; both the plaintiff and the defense use a VE to document or determine the damages. Often an estimate, prepared either by the defense or plaintiff witness, of the damages is used in an attempt to settle the case. The settlement is often the outcome of mediation where the defense's and plaintiff's estimates are compared and the result represents an agreed upon compromise between the two estimates of damages. At other times the VE's work is aimed toward a jury that will ultimately determine the award the injured party will receive. **A portion of the jury's determination is from special damages or compensatory damages. These damages relate solely to the real cost of the individual's injury and/or the cost of what they are likely to incur or experience in the future, such as medical costs or lost earning-capacity. Wage loss, as well as earning-capacity loss, are special damages that are documented by the VE.**

Wage Loss and Earning Capacity:

Wage loss and earning capacity loss are terms that are commonly confused. **Wage loss simply means the wages the worker lost as a result of being off work due to the injury.** If an attorney received a spinal injury in a car wreck and was hospitalized for six months, the attorney would lose wages or earnings while in the hospital. The calculation would be very simple: if the attorney works for a firm and earned $5,000/month, the wage loss would be $30,000, or 6 months @ $5,000/month.

On the other hand, if the same attorney suffers a head injury and can no longer work as an attorney, his loss is very different. **The earning-capacity loss depends upon the difference in monetary value between the occupations the injured party could pursue before and after the injury and subsequent disability.** The VE must determine if the attorney had reached an occupational pinnacle or plateau before the injury. If the attorney was a recent college graduate and had not practiced for a significant length of time, it is likely that the injured party's potential earnings as an attorney would have been much more than $5,000 per month. If the attorney had been out of law school for years and was very talented, chose to accept pro bono cases half of the time, and donated a significant amount of time to charitable enterprises, it is likely that the injured party's potential earnings as an attorney would have been quite a bit higher than the actual wage loss if projected to the end of his or her worklife expectancy. **The VE will calculate both the wage loss and the earning-capacity loss in determining the settlement.**

Worklife Expectancy:

Worklife expectancy is the estimate of the time the worker would be able to work until voluntary or forced (failing health, reduction in functional abilities, or death) retirement. This includes a calculation of reduced work hours the worker would be available to work, (i.e., part-time work, if the worker is unable to work full-time). The existing literature and/or data dealing with estimating worklife expectancy is, at best, not very good. Gamboa's The New Worklife Expectancy Tables[2] may be one of the best resources, but appears to overestimate the worklife expectancy of the severely disabled worker (head or spinal cord injury) and underestimate the worklife expectancy of the less severely disabled worker (individuals with long periods of rehabilitation and without great loss or functional limitations, or people who have had multiple injuries or reinjury resulting in significant off-work periods). Unfortunately, the Department of Labor (DOL) has stopped publishing their worklife tables. The DOL's last published worklife tables were in 1986 and were based on 1979 data. Due to the lack of resources many VE's delegate the issue of calculating worklife expectancy to an economist.

Expert Qualification

In this section the federal case laws that have shaped the current procedures and issues involved in qualification as a rehabilitation "expert" are discussed and clarified. Although the case laws reviewed are Federal, many states follow the Federal courts lead in qualifying experts. Before the VE begins to document the value of special damages, the first issue is to show that the VE is an "expert" or can be qualified as an expert. Being qualified as an expert can have different meanings in different venues. Fields and colleagues[3] **summarized the challenge of proving expertise as "showing first-hand knowledge of, not only general information, but of information specific to the claimant who is part of the adjudicating process."**

The Social Security Administration (SSA) system has specific requirements. **The SSA requires the expert to have a minimal level of relevant education, with a minimum of a B.A. in behavioral sciences, work experience as a rehabilitation specialist, and participation in the profession.** Participation in the profession refers to qualifying for and joining professional organizations, being a Certified Rehabilitation Counselor, and/or being familiar with professional literature. Relevant work experience referes to the VE having worked with similar clients and performed job duties that are considered standards of the industry, (i.e., labor market evaluations, vocational assessments, job analysis, and placement of clients with disabilities). Field and Sink[4] indicate that by meeting these criteria, the VE would generally meet the qualifications in a SSA hearing.

Frye:

Until recently the rules governing being qualified in federal courts were rather broadly defined. A person was required to have a history of understanding a particular field with a good or high level of knowledge, skill, or experience. The standard for the Federal court system was established in 1923 with a decision from Frye v. United States,[5] otherwise known as the Frye decision, and was followed by the Federal Rules of Evidence (with amendments to February 1, 1984). **The Frye decision provided a basis for determining if an expert's opinion would be admitted as evidence. In general, the Frye decision indicated that scientific evidence should be admitted if it was based upon evidence generally accepted in the specific field of knowledge. The concept was not restricted to science, but extended to trade or art, therefore not limiting the testimony to scientists, but including technicians as well. Anyone with special knowledge or experience could qualify as an expert under the Frye decision; rule 702**: "If scientific, technical, or other specialized knowledge will assist the trier of fact to understand evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise."

Daubert:

The following decisions are of specific importance to those interested in qualifying as an expert under the Federal Rules of Evidence (with Amendments to February 1, 1984). In 1991 Daubert v. Merrill Dow Pharmaceuticals[6] was appealed and forwarded to the supreme court of the United States and a landmark decision was made on this case in 1993.[7] **The Daubert decision addressed the admissibility of scientific testimony on the basis of being relevant and reliable, making the Frye standard, if not obsolete, at least no longer the standard. Fields[8] reports that in the Daubert trial the court identified five tests to assist the court in determining the admissibility of scientific knowledge:**

1. **A key question to be answered is, ordinarily, whether the theory or technique can be and has been tested;**
2. **A pertinent consideration is whether the theory or technique has been subjected to peer review and publication, although the fact of publication, or lack thereof, in a peer-reviewed journal is not a dispositive consideration;**
3. **The court should ordinarily consider the known or potential rate of error of a particular scientific technique;**
4. **The assessment of reliability permits, but does not require, explicit identification of relevant scientific community and an express**

determination of a particular degree of acceptance of the theory or technique within that community, as (a) widespread acceptance can be an important factor in ruling particular evidence admissible, and (b) a known technique that has been able to attract only minimal support within the scientific community may properly be viewed with skepticism; and

5 **The inquiry is a flexible one, and the focus must be solely on principles and methodology, not on the conclusions that such principles and methodology generate.**[8]

The Daubert decision has become the standard in Federal courts, but Frye may still be the standard in state courts. Currently, 26 states have adopted Daubert as the standard for qualifying experts.[9]

Kumho:

A debate followed Daubert regarding whether rehabilitation consultants or VEs were scientists or technicians and, in turn, whether their testimony would be subject to the principles established in Daubert. Some of that question has been resolved. **Kumho Tire Co. v. Carmichael[10] addressed the question of whether Daubert applies to experts who are not scientists, but who are technicians or persons with specialized knowledge. The outcome is that the judge as gatekeeper determines the admissibility of the expert's testimony. That testimony must be relevant and reliable, regardless of whether the expert is considered a technician or scientist.**

Methodologies

This section reviews the following methods of calculating earning capacity loss: the Transferable Skills Analysis/Labor Market Access Method (TSA/LMA), the Impairment to Earning Capacity Method, The RAPEL method, and The Interest Driven Evaluation and Assessment model (IDEA). The issue for the VE becomes understanding methodology; credentials, although very important in establishing professional status, are not sufficient in the qualification process. The VE must understand the methods used in evaluating earning capacity loss, the principals used in making these assessments, an awareness of the methods validity and reliability, and whether the method or theory has been published and subjected to peer review. Finally, the VE should have experience with the principles and methods used. This standard is quite different than what has been the benchmark in the past. In the past twenty years, numerous systems have been developed to assist the vocational consultant in determining whether a client is employable and, if so, at what level. Various systems or methods were developed for specific areas of concern. The methods developed by Dillman[11] (Impairment to Earning Capacity) and by Weed[12,13] (RAPEL) allow the VE to systematically evaluate the earning capacity of an individual with acquired disabilities.

TSA/LMA:

Fields[10] was probably the first to institute a practice or method for evaluating the value of loss, or extent of loss, suffered by a person with a disability; **his method is ideally suited for evaluating clients in the Social Security Disability Insurance system. *Transferable Skills Analysis* (TSA), as developed by Fields, has been used by vocational rehabilitation counselors to help clients with acquired disabilities find alternate work by utilizing skills the worker had before the injury.** This method has been in use since Fields introduced the use of the *Dictionary of Occupational Titles* (DOT) in the 1960s. Field's system is a highly formal, thorough method of using the DOT and worker traits with other related available data that allows the rehabilitation consultant to select jobs that are appropriate for the individual with a disability. The TSA method helps the consultant to identify a wide range of occupations that would be appropriate or inappropriate, given the functional abilities and limitations of the injured worker.

The TSA method was developed further to include documenting what percentage of the labor market the worker had access to before and after injury and disability. The difference represents the degree to which the person is disabled or the severity of the disability as it relates to the world of work. This process is known as *Labor Market Access* (LMA).[14]

Impairment to Earning Capacity Method:

Everett Dillman[11] developed the impairment to the earning capacity method after Field's contributions. **Dillman describes labor market access as the percentage of job titles or positions that the individual is now unable to perform but that he or she would have the ability to perform without the current limitations.** Dillman includes LMA as part of his formula representing the "impairment to the earning capacity." He expresses this relationship as the function of the relationships between the following variables:

Impairment to Earning Capacity = f (L, P, T, C)
Where: **L** = Reduction in labor market access
P = Reduction in the average pay for the residual jobs
T = Reduction in worklife or hours available for work
C = Reduction in the ability to compete and/or increase in rate of unemployment.

Dillman describes a very systematic procedure for estimating these values:

1. **Determining the LMA (the ratio of jobs the person now has access to with the disability versus jobs the person had access to before incurring the disability) of the injured party.**
2. **Estimating the average wage the worker had before becoming disabled versus current wages.**
3. **Estimating the reduction in worklife, employability, or availability of work that the worker is still able to perform.**

Although, Dillman's Impairment to Earning Capacity method does not provide an aggregate number representing a total loss of potential earnings, **it does provide the evaluator with a method to insure that they have included the main effects of disability on working. Also, the evaluator has a firm base from which to discuss those issues that don't produce a quantifiable number,** (i.e. C=reduction in the ability to compete and an increase in unemployment). The consultant generally can't estimate precisely the amount of unemployment the injured party will suffer as a result of disability, but, certainly, if the rate of unemployment is greater for the person with the disability than the general population than an estimate of the impact of this factor should be included in the final evaluation.

RAPEL:

The RAPEL method[12,13] was introduced in 1994 as the most comprehensive of all methods in determining earnings capacity loss.[15] The "**R**" in RAPEL refers to the rehabilitation plan that would return the disabled individual to work at a maximal or comparable level. The "**A**" refers to the labor market access the individual with a disability has both before and after onset of disability. The "**P**" refers to placeability, which is a description of the employability of the person. The "**E**" represents the pre- and postinjury earning capacity of an individual with a disability. The "**L**" refers to life expectancy or, better stated, the individual's "worklife expectancy." An individual who is severely disabled is not likely to work full-time, or without interruption, due to required or possible medical interventions. It is also likely that they will retire early due to health reasons. Like the Dillman model, Weed's model does not produce an aggregate number representing a "quantitative level of earning capacity loss and damages" but rather is a system to insure that the VE is thorough in conducting the earning capacity loss evaluation

IDEA:

The *Interest Driven Evaluation and Assessment* (IDEA) model is described as an alternative or additional method of evaluation that I have found to be valuable. The IDEA model (Figure 1) of vocational assessment is a straightforward method that is defensible and well documented in the literature. **The model is quite similar to what a practicing rehabilitation counselor would use when evaluating a client for vocational rehabilitation services if the goal was to maximize employability. Although I have coined the acronym, the model is essentially a career-counseling model.** I have used this model of evaluating employability and earning capacity quite successfully for more than twenty years in both state and federal courts.

Conceptually, the primary difference between IDEA and a TSA is the emphasis on where one starts with the evaluation and assessment. **IDEA emphasizes the client's interest as the primary and initial component of this process, then the VE assesses the client's aptitudes, abilities, the current labor markets, and which jobs are consistent with the client's interests.** A traditional TSA would focus on functional abilities and aptitudes to identify any job that would be appropriate given the client's abilities, often regardless of client interest. With the TSA model, the VE can use the *Guide to Occupational Exploration* (GOE) codes to sort occupations. If one restricted the TSA to only occupations in the same and/or closely related GOE categories the result would be similar to the IDEA model, but not as thorough or accurate; the primary benefit of the idea model is that it does not use the assumption that the worker has a high interest level in the occupation or occupations that the worker held before the disability, which may or may not be the case. I much prefer Holland's codes to GOE codes for identifying appropriate client occupations.

Figure 1
IDEA MODEL

1. Evaluate interests

- A. Assess expressed interests—determine if the client has reasonable understanding and expectations of occupations that are expressed
- B. Investigate hobbies and work history to assess evidence of manifest interest
- C. Administer tests that evaluate both Inventoried and Tested Interests (Strong Interest Inventory or Career Assessment Inventory)
- D. Develop list of Tentative Vocational Objectives (TVOs) consistent with evaluated interests,without concern for the client's aptitudes and abilities to perform the occupations or the available labor market

2. Evaluate aptitudes and functional abilities

- A. Paper-and-pencil testing using appropriate psychometrics to evaluate aptitudes
- B. Work evaluation to determine functional abilities,limitations,and potential accommodations and/or assistive technological solutions to identified barriers
- C. Review medical records to determine physical restrictions

3. Match aptitudes/abilities to interests

- A. Determine if the client has appropriate aptitudes and abilities with anticipated accommodations to be successful in the client's TVOs
- B. Eliminate occupations from list of TVOs that are not appropriate,and/or expand list of TVOs using Holland's codes to develop additional potential TVOs that may be appropriate

4.Determine availability of occupations that are consistent with the client's interests,aptitudes,and abilities

- A. Perform Labor Market Analysis for relevant TVO(s) using local,regional, and national data (including DOT and other governmental data sources) to document employment trends,job requirements,entry and journeyman level pay levels,etc
- B. Perform Job Analysis (if necessary) to insure occupation is physically appropriate,and/or appropriate given the recommended accommodations

Assessing Interest

The first step in the IDEA model is to assess interest, which can be determined in several different ways. Super[15] describes four types of measured interests:

- *Expressed Interests:* The client states that he or she likes some task or occupation: (i.e., "I would like to be a truck driver."
- *Manifest Interests:* The client has demonstrated an interest in the occupation through actions or behaviors. For example, the client makes cabinets and/or furniture in his or her own workshop as a hobby, demonstrating a possible interest working in this area.
- *Inventoried Interests:* Responses to interests inventories; sets of questions relating to likes, dislikes, and occupational interests.

- *Tested Interests:* **Revealed under controlled conditions, where items are crafted to distinguish between relatively equal situations and will determine the strength of the tested individual's interests.**

Some of these methods would appear to be more valid measures of interests than others, although if a client's stated interests are consistent with manifest and tested interests, the VE can feel comfortable that the assessment is headed in the right direction. Conversely, when the VE only has the client's stated interest, the validity of that measure depends upon the client's understanding of that particular occupation. **Quite often, clients are unaware of the realities of occupations in which they have stated interest.**

Some interest inventories provide information regarding both tested and inventoried interests. Inventoried interests would fall into a category referred to as basic or general interests and are homogeneous in nature.[16] These scales are designed to include items that are similar or related in nature.

Heterogeneous scales, referred to as Occupational scales, differentiate between the interests of people in a certain occupation and those of the general population.[16] These measures of interest are particularly valuable to the VE in explaining why an occupation is more appropriate than any other of the 12,000 occupations listed in the DOT. Understanding how an individual's profile is matched to certain occupational profiles is also very important to the VE in explaining why they believe that an individual will be successful in an occupation in which he or she has little or no experience or real awareness.

Ideally, using the theory postulated by Super,[15] if a person has stated a specific interest and demonstrates a manifest interest that is consistent with both tested and inventoried interest, the vocational choice would be appropriate. That success would also be contingent upon the person having the aptitudes and abilities to perform the job. Additionally, the VE would expect that there would be adequate labor market demand or, to use the term used by Weed,[12,13] that there would be adequate access to support the anticipated success of the proposed vocational objective.

In the IDEA model, the VE identifies general or basic interests areas and specific occupational areas, expands the possible occupations, then helps the client formulate *tentative vocational objectives* (TVOs). The TVOs are examined to determine if the client has the requisite abilities and aptitudes and if there is adequate labor market demand to support the TVOs. The VE and the client eliminate TVOs based upon identified barriers that are unlikely to be resolved, such as occupations that are so glutted with qualified workers that there is no discernible labor market demand. The remaining objective(s) most closely match the client's personality, interests, and skills, and it is reasonable to expect that the client will be (or would have been) successful in reaching the objective (depending upon whether the VE is assessing premorbid or postdisability vocational objectives). I have used this system since 1978 and have been able to convince juries that the vocational objectives identified are reasonable and likely to be attainable.

Validity

The validity of the model depends upon the rate of consistency that client interests (tested, stated, and manifested) predict the actual vocational outcome; this is predictive validity. Studies have shown that the predictive validity of the Strong Interest Inventory is quite good.[16-22] **These longitudinal studies have shown that 55%–70% of the people who take the Strong Interest Inventory will become employed in an occupation consistent with the highest scored occupation.** These percentages are impressive, considering all the factors that go into finding the desired job. Besides having an interest, an individual needs the abilities, aptitudes, motivation, and skills to find the openings, the skills to interview for and gain the job, as well as a good measure of luck. That approximately 55%–70% of individuals who take the Strong Interest Inventory are finding jobs consistent with their tested occupational interests far exceeds what one would expect by sheer chance alone.

So far, we have addressed the issue of successfully matching clients with jobs, but we have not addressed the issue of clients finding jobs and being successful in them. **The concept of success in the chosen occupation (given that the client has the requisite abilities and interests) is at the core of Holland's theory of vocational choice. Holland[23] theorized that mem-**

bers of a vocation have similar interests, creating what he termed a "characteristic interpersonal environment." Holland states that satisfaction, stability, and achievement are contingent on the compatibility of the work environment (created by those personalities that dominate the work environment, i.e., the owner, the supervisor, the leaders in the field) and the client's personality. The tests that use Holland's theory, ***The Strong Interest Inventory, The Career Assessment Inventory, and The Self-Directed Search,*** to name a few, predict successful participation in the occupation if the individual has the requisite skills, abilities, aptitudes, etc.

IDEA Model Conclusion

The IDEA process is very consistent with the model that many vocational rehabilitation counselors use every day in practice. The model is one that, logically, you might use to find your own job. Ask yourself, "If you took a job that you hated, even if you were good at it, outside of some extenuating circumstance that forced you to keep that job, what are the chances of long-term success?" One would think that long-term success is not very likely. So why would you take a job you don't like, and why would you expect someone else to take a job they don't like and be successful at that job? There really is no good answer. On the other hand, if you were planning a career for yourself you would start with those things you like to do and work from there. **This model allows the VE to explain how an occupation might be appropriate for an individual, regardless of the client's familiarity with that occupation. At the same time, it allows the VE to explain why an occupation would not be appropriate for a client who has the apparent skills and abilities.**

Finally, the VE takes the predisability earning capacity and subtracts the value of the estimated postdisability earning capacity to calculate earning capacity loss. The VE or the economist would also calculate the effect of worklife expectancy on the earning capacity loss. Also, the cost of the proposed rehabilitation plan would be assessed to determine the cost to mitigate the affects of the disability.

Summary

Since the Daubert and Kumho decisions, it is not enough for a VE to testify that he or she worked, for example, for a state or federal agency for 12 years, carrying a caseload of severely disabled clients. The VE is no longer able to establish credibility and expect the court to accept testimony solely on the basis of "professional experience." Regardless of what model or combination of models used in determining lost earning-capacity, the VE needs to understand how the model(s) works, if the model has been tested, if it is valid and reliable, and if it has been peer reviewed. Is the model used in real-world settings? Can the VE explain the model to a jury or to an opposing attorney in a deposition in a convincing, understandable, and reasonable manner? All of these issues must be addressed. All the models and methods discussed in this lesson have value; no matter which model is used, the VE needs to fully understand the principles involved in the methodology. I have relied upon my IDEA model for years because I find that it is the best model for working with people with disabilities outside of a forensic setting. This feature allows the VE to speak in terms of their everyday practice rather than in terms of some esoteric practice that they only occasionally utilize for forensic cases. I have found the IDEA model useful in defending my evaluations in a forensic setting.

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Questions Based On This Lesson

To earn CE credits,answer the following questions on your quiz response form.

29. Of the different types of damages, which one is the vocational expert expressly and professionally interested in?

A. Hedonic

B. Pain and Suffering

C. Punitive

D. Special

30. In what way does wage loss differ from earning-capacity loss?

A. Actual earnings versus potential earnings

B. Wage loss during rehabilitation period versus wage loss from shortened worklife expectancy

C. Potential wage loss due to unemployment losses versus potential losses due to reduced ability to compete

D. Losses from limitations in employment versus gains from settlement

31. Recent case law has had a significant impact on qualifying experts. Which case(s) stands as a precedent on the question of admissibility of expert testimony in federal courts?

A. Frye

B. Kumho

C. Duabert and Frye

D. Kumho and Duabert

32. Which model has been reported to be the most comprehensive method of evaluation?

A. TSA / LMA

B. Impairment to Earning Capacity Method

C. RAPEL

D. IDEA

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Thank you for participating in Hatherleigh's continuing education program. This section concludes your course. Please remember to keep a copy of your quiz response form for your records.

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Directions in Rehabilitation Counseling
Volume 12 Lesson 9

Latino Culture and Mental Health in the USA

Renato D. Alarcón, MD, MPH

Dr. Alarcón is Professor and Vice-Chairman, Department of Psychiatry and Behavioral Sciences, Emory University School of Medicine, and Chief, Mental Health Service Line, Veterans Administration Medical Center, Atlanta, GA.

Introduction

This lesson attempts to explore several aspects of the mental health needs of the Latino/Hispanic segment of the U.S. population. It examines epidemiological data, assessment of needs, treatment, and clinical outcomes, as well as the cultural characteristics of this population and the repercussions of their concepts of health and disease. Emphasis will be placed on the practical applicability of this information.

Culture plays a significant role in Latinos' attitudes about health in general and mental health in particular. Cultural beliefs and traditions create both positive and detrimental effects on the behavior of Latino patients and their families in relation to mental illness. For example, while social support networks are broad and strong, thus preventing the problems of abandonment and neglect, a Latino's powerful sense of privacy may impede an early and fully compliant response to the need for treatment. If socioeconomic status is considered (as it should be) part of the of the patient's cultural surroundings, its impact on the affordability of mental health services may be as important as the reluctance and reservations with which Latino communities perceive such services. Acculturation, the process by which immigrants adapt to the rules and behavioral characteristics of their host society, also has a significant impact on perception and response to mental health services. The end result of these processes is that mental health facilities are underutilized by the Latino population.

GROWTH OF THE LATINO POPULATION:

The growth of the Latino/Hispanic population (immigrants and American born) in the United States is one of the most impressive demographic phenomena of the 20th century. **As of 1999, the country had more than 30 million Latinos, or people of Central or South American descent,[1] almost 60% more than in 1980** (12 million Latinos)

and 650% more than in 1960 (four million Latinos). Population projections show that by 2005 Latinos will number over 36 million, and will constitute 13% of the U.S. population, which will represent the largest minority group in the United States. **By 2030 Latinos will outnumber African Americans by nearly 22 million, with a total of 75 million; it is estimated that 75% of these Latinos will be U.S.-born.**[2]

Large areas of what is now the southwestern and western United States were populated by Spanish-speaking, or Hispanic settlers as recently as the late 19th century. **At the present time, the United States has the fifth largest population of Spanish speakers in the world.** It has the largest Puerto Rican population in the hemisphere, the second largest concentration of Cubans, Salvadorans, Haitians, and Jamaicans, the city with the second largest population of Spanish speakers in the world, and the fourth-highest number of Mexicans in the world.[3]

The main Latino subgroup in the United States is of Mexican origin, with 62% of this population living in the West and Southwest. Of the Puerto Rican subgroup, 57.9% live in the Northeast, particularly in New York City; 27.3% of Cubans are located in Florida and the Southeast; and 30.9% of Central and South Americans are located in the South and Midwest. In 1999, the states with the largest number of Latinos were California, Texas, New York, Florida, Illinois, Arizona, and New Jersey. Those with the greatest growth of the Latino population between 1990 and 1998 were Arkansas, Nevada, North Carolina, Georgia, Nebraska, and Tennessee.[4] In addition, Latinos are the only ethnic group with a mean age under 30 years (28.9), which contrasts with the considerably older average age of non-Latino whites (38.6 years).[5]

While the numbers are impressive, the social and economic situation of Latinos is discouraging (see Table 1). In 1996, **high school and college education levels were much lower for Latinos than for non-Latinos, and one–fourth of Latino families fell below the poverty line,** with Puerto Ricans and Mexicans being especially affected (with poverty rates of 33.1% and 27.7%, respectively). The poverty level was even higher for children under 18 years of age. **Latinos also have the lowest rate of health insurance among the major U.S. ethnic groups,** with 35.3% actually lacking any insurance, 44% of this group are among the Latino poor.

On the other hand, **Latinos' position on the income spectrum seems to be improving.** *A recent California study showed that during the 1980s, the number of middle-class Latinos in Southern California grew three and one–half times faster than the number of Latino poor.*[6] *Between 1987 and 1993 there was an 83.7% increase in the number of Latino-owned businesses, and, in 1999, Latino purchasing power was approximately $400 billion, 84% more than in 1990.*

General Characteristics of Latino Culture

Culture is defined as a set of meanings, behavioral norms, and values used by members of a particular society to construct their unique view of the world. These reference points include habits, customs, political beliefs, social relationships, ethical standards, religious faith, technology, and financial philosophy; as well as material elements such as diet, clothing, tools, or housing. Culture influences the development of per-

Table 1

MAIN SOCIOECONOMIC CHARACTERISTICS OF LATINOS IN THE UNITED STATES (1996–1998)

	Latinos	Non-Latinos
Proportion with high school degree (among those over 25)	54.7%	84.8%
Proportion with no college education	66%	41%
Proportion of families below poverty line	24%	12%
Proportion of children under 18	40%	17%
Proportion with no health insurance	35%	22%

Sources: US Bureau of the Census. Resident Population Estimates of the United States by Sex,Race, and Hispanic Origin:April 1,1990, to November 1, 1999. Population Estimates Program, Population Division.Internet release date: December 23, 1999; US Bureau of the Census. Population Profile of the United States: 1997. Washington, DC: US Government Printing Office; 1998. Current Population Reports, Special Study P23-194; Lopez SR. The mental health of Hispanics in the United States. Presented at the National Congress for Hispanic Mental Health; March 20–21, 2000; Washington, DC.

sonality, self-concept and self-image, and individual behavioral styles through parental attitudes, child-rearing methods, and the ever-powerful use and transmission of language.[7] As a repository of traditions and customs, culture, along with ethnicity, shapes personal and group identities.

Despite their diversity, there is enough consistency in the main cultural foundations of Latino groups to speak of common characteristics. **The Spanish language is certainly the most significant link, as more than 75% of Latinos speak it everyday. About 85% are Roman Catholic** and, ethnically, more than 80% are mestizo, the product of ***mestizaje.***

Group identity for Latinos remains focused around *familismo*, which encompasses familial obligations, perceived family support, the family as a behavioral-attitudinal referent, and hierarchization, or well-established roles and lines of authority.[8] ***Familismo* is an allocentric or sociocentric feature, emphasizing the interests of the group over those of each individual.**

Other characteristics of Latino culture are *simpatia,* or the need for behaviors that promote smooth and pleasant interactions between the members of the group, and *respeto* (respect), **particularly from younger to older persons, from women to men, and from all group members to persons in authority or higher socioeconomic positions. The above notions of *familismo, simpatia,* and *respeto* also determine generational expectations of material, economic, and social improvement.**[9]

Personal identity and traditional sexual roles among Latinos are defined by ***machismo*** for men and ***marianismo*** for women.[10] **The former,** more than male physical dominance and sexual availability, **includes the obligation to play the role of a provider who is responsible for the welfare, protection, honor, and dignity of his family. *Marianismo* refers to the spiritual superiority of women and their capacity to endure all suffering, which insures survival and power through the children.** Pride is often associated with "being strong," being able to control or resign oneself, withstand stress, and accept fate; it follows that shame will fall upon those who have little or no self-control and who are less able to exercise personal responsibility.[11]

Communication styles include an often-described loquaciousness, mixed with reluctance or guardedness toward strangers (particularly at the beginning of an encounter), frequent use of nonverbal approaches, and a tendency to develop dependent relationships. Not unrelated to the above roles is the emphasis on privacy and the closeness of parent–child relationships in Latino culture.

The perception and use of time and space have unique characteristics among Latinos. A tendency to focus more on the present or immediate future, than on the long term, may either be a defensive posture or, rather, reflect rejection of unwanted pressures and the lack of a destructive sense of urgency. Translocation of time (the convergence of different time periods into one), the collective, transgenerational memory, and the "magic realism" present in many literary and artistic forms serve the same purpose. Finally, personal space among Latinos is relatively limited; allowing for close, relatively uninhibited physical contact and affective expressiveness between individuals.

Strong Catholic (but also growing Protestant) values play a significant social role in cementing relationships among individuals and groups. The position of the Catholic Church on sex-related issues, including abortion, premarital intercourse, and birth control, has also become significant in light of the current AIDS epidemic among Latinos. However, many Latinos mix Christian religious practices with rituals derived from a pre-Columbian sets of beliefs, a syncretism that creates what some anthropologists call "pagan Christianism," and the search for "saints" and divine messengers; this can also be seen in European Catholicism.

ISSUES OF HEALTH AND ILLNESS:

The high religiosity of Latino culture, and the tendency to equate spiritual and physical strength, produces a firm belief that health is a God-given state. Good health implies congruence with God and harmony with the family, other persons, and the rules of the church;[12] ***consequently, illness may be fatalistically seen as punishment.*** Because of this, treatment generally occurs in the context of a so-called "therapeutic dualism." This is the offering of mixed explanations about the etiology of diseases—a combination of biological, body-related failures, and the impact of external factors, including extraterrestrial, cosmic notions. **This makes Latinos more willing to delegate problem-solving responsibilities to others; especially figures of authority, such as doctors and health professionals.**[13]

On the other hand, folkloric medicine practices and the rituals of folk healers (*curanderos*), shamans, herbal doctors, and others, are perceived as acceptable avenues of care and constitute a good portion of the informal medical system for Latinos in the United States.[14] Folk healers from different Latino subgroups share common elements in their work, including diagnostic approaches, cures, invocation of spiritual helpers, use of herbs, trance-like states, and proper social etiquette. It is easy to see the features of simpatía, personalism, hierarchization, shame, and guilt as cultural referents of all these practices. A good number of Latino families would prefer (at least initially) to send a mentally ill family member to a folk healer because of a sense of shame for being ill in the case of the patient, and for causing the illness, in the case of relatives. Similarly, the perception of, and subjection to, authority by Latinos is more pronounced than in the egalitarian style of the general American culture.

For Latinos, the perception of death as a crucial event in the human experience connects cultural fatalism or "teluric pessimism" with intense religious expectations of an afterlife. The strongly held belief of happiness in heaven makes the use of life-prolonging measures in terminal patients a source of potential conflict. Latinos also show very high affective expressiveness of grief in the wake of the death of loved ones.[8]

MENTAL HEALTH ISSUES:

Contemporary psychological theory considers culture to be involved in many elements of mental health; it is an interpretive and explanatory tool for nonpathological human behaviors, a pathogenic and pathoplastic agent, a diagnostic and nosological factor, a protective and therapeutic element, and an instrument in the structuring and management of clinical services.[7] As an explanatory tool, Latino culture assists in identifying some group-induced hallucinatory experiences during folk-healing and religious rituals as regular components of such practices, and not as expressions of psychopathology.

The cultural meanings of somatic symptoms, as expressions of emotional discomfort, have been noted in Latinos. Histrionic personality is a diagnostic label frequently misapplied to individuals of Latino origin who exhibit loud expressiveness, and whose culture accepts what may be violations of privacy in other cultures.[15]

In the pathogenic/pathoplastic area, social and culture-laden experiences of conflict, guilt, stress, or fear may result in "culture-bound syndromes." These are recurrent, locality-specific patterns of aberrant behaviors and troubling experiences[16,pg. 844] **that have well understood, coherent meaning within the culture that produces them. Culture-bound syndromes in the Latino culture include susto (*fright*), *espanto* (*terror*), *mal de ojo* (*evil eye*), and the much-discussed *ataque de nervios*, a well-defined condition that resembles, but is not identical to, panic disorder as described in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition** (DSM-IV).[16]

Epidemiological Research

In the last 20 years, a handful of epidemiological surveys have directly or indirectly addressed the mental health of Latino populations in the United States.[17-22] (See Table 2) Although different in methodology, objectives, and locales, these and other studies have yielded abundant and useful information. Some of the main findings are listed below:

- **The health and mental health status of Latinos decreases as Latinos acculturate to the U.S. way of life.**[21,23,24]
- **Mexican immigrants have considerably lower lifetime prevalence rates of major mental disorders than do U.S.-born Mexican-Americans (24.9% versus 48.1%, respectively).**[21,25]
- **U.S.-born Mexican Americans have prevalence rates of any mental disorder nearly identical to that of the national sample (48.6%).**[19,21]
- **Latinos have a significantly higher prevalence of current affective disorders and active comorbidity than non-Latino whites.**[19,21]

Table 2

MAIN EPIDEMIOLOGICAL RESEARCH STUDIES DEALING WITH LATINO MENTAL HEALTH IN THE UNITED STATES

Hispanic Health and Nutrition Examination Survey (1982)
Epidemiological Catchment Area Survey (1984)
National Comorbidity Survey (1994)
National Household Survey on Drug Abuse (1997)
Mexican-American Prevalence and Services Survey (1998)
Youth Risk Behavior Surveillance (1998)

- **Latinos' use of drugs was lower than non-Latino whites' (especially among women), particularly in the case of marijuana, inhalants, hallucinogens, and the nonmedical use of prescription drugs.**[20]
- **A greater percentage of adult Latinos were either binge drinkers or heavy users of alcohol (16.9% and 6.3%, respectively) than non-Latino whites (15.5%/5.2%) or African Americans (10.8%/3.9%).** [20]
- **Among Latinos, 1.4% report using heroin, compared with 0.9% in non-Latino whites and 1.0% in African Americans. Among Latino men, 3.2% report having used cocaine in the past year (and 1.4% in the past month), versus 2.4% in the past year and 0.7% in the past month for non-Latino whites.**[22]
- **Mexican-origin youth suffer from significantly more depression and suicidal ideation than Anglo-American and African-American youth.**[24,26] **Ten percent of young Latino men and women have attempted suicide, and 23% have considered it, compared to 7% and 23% of African-American youth.**[22]

Use of Mental Health Services

One of the earliest reports of Latino *underutilization* of community mental health services showed that only 6% of more than 11,000 psychotic patients in Texas state hospitals between 1951 and 1952 were Spanish surnamed, compared with 84.6% of Anglos and 9.4% of African Americans.[27] The Latino proportion of the Texas population at the time was 15%. The Epidemiological Catchment Area (ECA) survey also reported that Mexican Americans use[28] health or mental health services at a lower rate than non-Latino caucasians (11.1% versus 21.7%). Low-acculturated Mexican Americans were particularly infrequent users of mental health services (3.1% versus 11.3% for highly acculturated Mexican Americans and 16.0% for non-Latino caucasians).[29] In the Mexican-American Prevalence and Services Survey study in Fresno County, California, only 4.6% of those born in Mexico sought services from a mental health professional, versus 11.9% by those born in the United States.[21,30] Interestingly enough, **the first choice for eventual care of mental health or substance use problems for those born in Mexico was not a mental health professional but a primary care provider, or even nonmedical individuals such as priests, friends, coworkers, or folk healers.**

In studies conducted at outpatient and inpatient public facilities in California,[31] and in a low-cost university outpatient center,[32] Mexican Americans were found to be underrepresented at the facilities. The same findings apply to Puerto Ricans in Connecticut, who use services 3.5 times less than African Americans and have high dropout rates.[33]

Although psychological distress was much higher among Puerto Ricans,[34] some of that distress may be manifested as somatization disorder, a common form of clinical presentation for depression among Latinos that increases reports of physical health problems and use of general health services.[35,36]

There is also evidence that Latino children have considerable unmet mental health needs. Leaf and colleagues[37] found that while the rate of mental disorders among Latino children in four communities was 32.2%, only 14.9% of them received mental health services, and only 8.1% received services in the specialty mental health sector. Reasons were manifold: lack of information, reluctance to seek help, financial limitations, or unavailability of services.

In general, older Latinos appear to experience greater absolute and relative economic, mental health, social, and health disadvantages than other ethnic minority elders in the United States.[38,39] A study showed that connection to the service delivery system, especially through insurance coverage by adult children, had the greatest impact on physician use by the Latino elderly, over and above physical and functional status.[40] Cuban Americans and Puerto Ricans were, respectively, 2.3 and 2.6 times more likely to have seen a physician than were Mexican Americans.

One of the few studies in the private sector used a 120,000-member health maintenance organization (HMO) operating in a major metropolitan city and its major suburbs.[41] The authors randomly sampled Latino surnames in the HMO membership and found that a total of 23% members were Latino, yet referrals of such patients to the mental health section in the HMO reached only 8% per year, about half of the overall psychiatric referral levels for other groups.

Additional findings regarding mental health service utilization include the following[21,30]:

- **Service users were more likely to be male, over 45 years of age, have incomes under $18,000 per year, be unemployed, and be functionally impaired; still, *the most powerful predictors of utilization were being U.S.-born and having more than one diagnosis.***
- **Use of mental health or informal providers was highest among those with combined mood and anxiety disorders.**
- **Nonmedical professionals were the providers most likely to be seen for mood disorders; medical providers were more likely to be seen for anxiety disorders alone, for combined anxiety and mood disorders, and for substance use disorders;** and both medical providers and other professionals were likely to be seen by patients with a dual diagnosis.
- **U.S.-born respondents were much more likely to use every type of medical provider except informal ones (e.g., social network members).**

A variety of culturally determined explanations for Latinos' underuse and premature termination of contacts with mental health services have been offered (See Table 3).[31,34,42] Briones and colleagues[43] dismiss the debate on underutilization focused on minority status (demographic/socioeconomic concept) versus ethnic perspective (cultural concept),[44] and propose a multidimensional model in which gender, age, ethnicity, and one's readiness to seek and use professional services are influenced by such factors as socioeconomic status, stressful life events, or inclusion within a social support network. **Using depression as a help-seeking condition in a stratified random sample of respondents in El Paso, Texas, they found that higher socioeconomic standing favored meaningful support which, in turn, decreased the probability of depressive symptoms. On the other hand, socioeconomic status induced a relatively small positive direct effect on utilization readiness, thus confirming that the availability of insurance alone does not increase significantly the level of hospital use.**[35,41,45] While life stresses are an important motivating factor in a person's decision to seek help, multiple factors converge to enhance or diminish use of mental health services, rather than a single dominant factor, such as ethnicity, being the final determining agent .

When considered against the background of the growth of the Latino population, the Latino mental health workforce in the United States is decidedly small (See Table 4).[3,46] **Less than 10% of the 36,000 Latino physicians in the United States are psychiatrists.** In addition to recruitment efforts, other mechanisms must

Table 3
CULTURALLY DETERMINED FACTORS FOR LATINO UNDERUSE OF MENTAL HEALTH SERVICES

- Overprotectiveness of family members against strange and feared social institutions.
- Masking of mental disorders by conditions such as heavy drinking, drug abuse, or criminal behaviors
- Greater tolerance of mental illness than in other ethnic groups
- Pride, deep sense of privacy, shame, or embarrassment, with return to the homeland (in the case of immigrants) as an alternative
- Preference for the use of folk healers
- Language barriers

be pursued such as an increase in cultural sensitivity and cultural competence among non-Latino professionals, the expansion of mentorship programs, and greater public awareness of the need to face the complex demands of the country's demographic diversity.

Cultural Aspects of Specific Clinical Entities

DEPRESSION:

Although cultural factors play a role in the clinical presentation and course of practically all nosological disorders, **depression is by far the most frequently studied clinical condition. Predictive factors of depression among Latinos are female gender, physical illness, diminished self-perception of health status, perception of many unmet needs, and a feeling of impotence or lack of control about everyday life demands. Low socioeconomic and educational level and a high degree of social isolation are also correlated with depression among Latinos.**

The stress factors more frequently associated with depression in Latinos are belonging to an ethnic minority, going through the immigration process, and dealing with the pressures of adaptation and acculturation in American society.[47] The premigration stress is intensified during the postmigration period by *changes in the gender role experienced by a Latino woman: Once in the United States, having found a job market larger and more open than in her country of origin, she often adopts the role of "breadwinner,"* generating hostility and criticism from a husband who may be more vulnerable to the risks of unstable or transient occupations.

In spite of being more at risk for depression than African-American women, **Latino women show less frequency of suicide attempts,** perhaps because of the social stigma attached to suicide by the Catholic Church. **The coexistence of depressive symptoms with a variety of somatic manifestations** (for instance, chronic abdominal pain in 20%–40% of patients) **is another consistent finding in Latino populations.**[35,36]

Table 4

LATINO SEGMENT OF U.S. MENTAL HEALTH WORKFORCE AND STUDENT POPULATION (1999)

Occupation	Latino Proportion of Workforce
Psychiatrists	6%–8% (2,100–3,200 total)
Members of academic departments	3.5%–5.5%
Psychiatric residents	6.5%–8.7%
International Medical Graduate psychiatric residents	57%
Medical students	8%
Psychologists	2%
School psychologists	2.6%
Psychiatric social workers	5%
Psychiatric nurses	0.9%
Mental health counselors	1.8%
Marriage/family therapists	0.8%
Psychosocial rehabilitation technicians	6.4%
Recipients of doctorate in Psychology	3.4%
Recipients of Master's degree in Psychology	4%
Recipients of Bachelor's degree in Psychology	.8%

Sources: Alarcón RD. Hispanic psychiatry: From margin to mainstream. *Transcult Psychiatry.* (in press), 2000; Lu FG, Lee K, Praphikanti S. Minorities in academic psychiatry. In J Kay, ed., *Handbook of Residency Training and Faculty Development.* American Psychiatric Press, Washington, DC, 1998.

PSYCHOTIC SYMPTOMS:

Psychotic symptoms described by Latino patients are different from those in other populations, as they may include atypical auditory and visual hallucinations (doorbells, telephones ringing, voices of children, and visions of animals or relatives) **without evidence of a formal thought disorder.**[48] **These psychotic symptoms are seldom part of the chief complaint, and Latino patients do not seem as troubled by these symptoms as patients of other ethnicities. The finding that patients with schizophrenia have a better prognosis in underdeveloped countries, or in rural areas of industrialized nations, than in urban**

industrialized areas[49] clearly applies to Latino families and communities in the United States. Their culturally based tolerance and acceptance of chronic schizophrenic patients differ from the isolation and rejection that these patients find in urban areas of Western countries.

ALCOHOL DEPENDENCE:

Some authors relate the high prevalence of alcohol abuse and dependence among Latino males to cultural factors such as machismo, high levels of tolerance from families and communities toward alcohol intoxication, and the accepted notion that Friday or Saturday may be used by the head of the household to "go out with friends and drink the weekend away."[50] Dual diagnosis, the combination of alcohol or substance abuse with another psychiatric diagnosis, is as prevalent among Latinos as in any other ethnic group.[51]

Alcohol disorders among Latinos appear to approximately double the risk of major depression for men and triple it for women. Golding and colleagues[52] found that low income, female gender, and low acculturation were associated with increased risk of secondary depression in 12% to 18% of Latino patients with a history of alcohol abuse or dependence. These disorders were typically more likely to precede major depression than to follow it. "Drinking to forget" was associated with increased risk of secondary depression among Mexican-American alcoholics, and current abstinence was associated with greater risk among lifetime alcoholics born in Mexico than among those born in the United States.

ANXIETY DISORDERS:

Among the anxiety disorders, posttraumatic stress disorder is seen more often in Latino veterans than in other groups.[53] Central American immigrants displaced by the civil wars during the late 1980s and early 1990s also show a peculiar "survivor's paranoia" in the context of their posttraumatic stress disorder.[10,54]

CULTURE-BOUND SYNDROMES:

Ataque de nervios is perhaps the most typical "culture-bound syndrome" in Latino populations. Initially diagnosed in Puerto Rican patients, it is now believed to also occur in other Spanish-speaking Caribbean countries as well as other Latin American regions.[16,55,56] **Following a psychosocial stressor, the afflicted person exhibits impulsivity, dissociation, and communication and perceptual disturbances.** The symptoms often begin in the presence of the family, allow a temporary relinquishing of social roles, and result in the mobilization of the social network in support of the person.[16] While some researchers[34] have demonstrated that ***ataques*** are, or can be, considered, at least in part, a variation of DSM-IV's panic disorders,[16] others conclude that they are also "idioms of distress" in communities and individuals under emotional pressure or a more acceptable way to designate stigmatizing disorders such as schizophrenia.[49]

Idioms of *anger* are salient in the conception of mental health among low-socioeconomic-status inner-city Puerto Ricans.[57] Expressions of aggression, assertiveness, and vindictiveness (mostly shown by people not receiving mental health services) **correlate with depressive and anxious symptomatology and are directly related to patient or nonpatient clinical status.** Furthermore, selected mood, personality, and impulse control disorders, as well as disorders of childhood and adolescence (e.g., conduct disorders), are rooted in part in feelings of anger and hostility.

DEMENTIA:

In bilingual Latino patients with ***dementia,*** Mendez and Estrada[58] found a significant decline in the ability to use English, their second language. **In attempting to speak English, the patients were affected by cross-language interference with Spanish, which contributed to a faster deterioration. The authors concluded that *the quality of life of these patients could improve and the total cost of their care could be reduced if care providers were able to speak the patient's original language.*[59]**

ACCULTURATIVE STRESS:

Acculturation, the process by which immigrants adapt to the rules and behavioral characteristics of the host society, has pervasive, intense, and unique features. Smart and Smart[60] identify six characteristics that differentiate Latino immigrants from their white, Protestant, Northern, and Western, European counterparts:

- **The Latino immigrants' tendency to accept and integrate with people of varying skin colors**
- **Their emphasis on social and family ties**
- **Their reliance on physical labor**
- **The geographic proximity of their native lands to the United States**
- **Possible illegal status or risks**
- **A legacy of armed conflict**

Acculturative stress **among Latinos stems from rapid social change, language barriers, and intergenerational conflict "cultural shock" in facing a rather individualistic social philosophy.**[61,62] Such stress is created when environmental or internal demands tax one's ability to cope and adapt. It is clear that acculturative stress affects physical health, nutritional patterns, sexual practices and habits, socioeconomic location, access to services, and the assessment of potential stress and risk factors themselves.[61,63] **What is less known is that such stress also affects decision making, impairs occupational functioning, and contributes to role entrapment and status leveling. It is also a factor in strained and ineffective therapist–patient relationships.** Acculturative stress, furthermore, thrives on the lack of role models and is increased when there are minimal rewards for learning English.[64,65]

Treatment/Management Issues and Latino Culture

The two main treatment modalities in clinical psychiatry, psychotherapy and pharmacotherapy, have strong cultural implications, particularly in dealing with Latino patients. Psychosocial approaches (which include psychotherapy) aim at enabling the patients and their families to learn how to successfully manage their condition; these approaches use cultural and linguistic resources. Psychopharmacological treatments in Latino patients involve unique issues both at the pharmacokinetic and molecular level (with some genetic basis such as susceptibility to the same medications in members of the same family) and at the level of culturally determined factors associated with the perception, meaning, and use of these treatments. Finally, the management of service delivery also involves significant cultural components.

PSYCHOTHERAPY:

Clinicians must consider cultural factors in the plight of their Latino patients. In addition to using DSM-IV's cultural formulation,[66] **the "cultural lenses" assumed in clinical practice with Latinos[67] must posit the importance of factors such as family dynamics, conflicts and interactions, the expression of psychopathology in the context of the Latino culture, understanding the paths to health and mental health services in these communities, and evaluating the professional training of health and mental health specialists.** ***Clinicians should consider the impact of adverse social, environmental, and political factors in assessing problems and designing interventions, and should actively work to eliminate biases, prejudices, and discriminatory practices.*** Beliefs about the cultural meaning of symptoms, the underlying culture-specific explanations of disease and illness, and the therapeutic engagement should be specified. Clinical judgment should help delineate who defines the problem (client or therapist?), the help model, the norms being followed, communication patterns, and values at play.

Verbal communication with Spanish-speaking patients has its own set of challenges. **Using both Spanish and English in whichever ways are most comfortable for the patient has been recommended, a procedure called "language switching."[68] It is also valuable to incorporate the family and social support systems, such as school and church, and to involve active outreach and follow-up via phone calls and letters in treatment.** Marcos[69] has written extensively about the advantages of **using the patient's native tongue, which facilitates emotional expression, spontaneity, and mending of intellectual differences and control struggles.** As the presence of sufficient bilingual providers is still a goal to be reached, the use of carefully selected professional interpreters appears to be the only valid option to achieve effective communication. Jacobsen[70] rejects the use of volunteer interpreters and favors an appropriate assessment of patient literacy levels and the development of appropriate Spanish language materials.

The debate about the use of insight-oriented psychotherapeutic techniques among Latinos appears to have been resolved in favor of a more individualized treatment.[71–73] Linguistic affinity or differences between patient and therapist generate clear transference and countertransference issues. Likewise, the presumption of sameness may lead to "fusion" and overidentification, while marked differences may lead to distancing through mutual devaluing.[74] Ruiz focuses on the hierarchy of the patient's needs, stressing the immediacy of counseling aimed at the basic problems.[71] Szapocznik et al[75] suggest an "isomorphic pattern" of treatment, that is, a mirror-like relationship between patient and therapist based on the respectful handling of the values professed by the patient. The isomorphic reinforcement of cultural traits implies that they are necessarily adaptive and modified according to the implicit goals of therapy without impugning their value and purpose as functional cultural traits in the immigrant's society of origin.

In the psychotherapeutic management of depression, clinicians must keep in mind the strong influence of pride in the cultural background of Latino patients, who also tend to develop a subtle, but evident dependent relationship with treating professionals; this behavior may wrongly be interpreted as evidence of therapeutic succ[illegible]n this context, clinicians must evaluate as objectively as possible the progress made in treatment to decide when to combine counseling with medication and, more importantly, when they have reached the limits of their ability to manage the depressive condition. Finally, clinicians must inquire carefully but firmly about suicidal ideation or intentions, contact relatives or friends if they are convinced of the seriousness of such statements, consider a "contract" with the patient (based on the latter's *palabra de honor* [word of honor]), another very important cultural element among Latinos, or decide rapidly on more drastic measures.[3,7,63]

The treatment of stress-related disorders in Latinos (including chronic pain, migraine and tension headaches, and lower back pain) has shown success with biofeedback-assisted relaxation training.[76,77] Management of sexual problems, sex role expectations, and norms that guide intergender relationships among Latinos is another area of interest.[65] **Experiences of emotional intimacy threaten the Latino cultural discourse of boundaries between men and women, and may lead to impasses in therapy secondary to enactments of pathogenic aspects of machismo and marianismo in the therapeutic relationship.**

The management of violence among Latinos requires a focus on battering and domestic violence, child and sexual abuse, sexual harassment, and other forms of victimization.[78] The use of cultural metaphors in the case of Latino burn and chronic pain patients,[79] or of cultural superheroes and "magical realism" for traumatized Latino children have been proposed.[80] Using metaphors in therapy is not new. Recent findings about symbolic empowerment and fantasy used in the service of health support the value of this approach.

In the field of family therapy, three frameworks have been developed and applied to Latino groups:[81,82]

1. **The *communicative-interactive framework*, emphasizing processes between individual family members and subsystems within the family, including communication, conflict, role relations, and decision-making.**
2. **The *structural-functional framework*, emphasizing the active, organized wholeness of the family unit and strengthening the ability of the family to maintain boundaries and thus serve stability and equilibrium needs while interacting with other systems and with society as a whole.**
3. **The *ecosystem framework*, which focuses on adaptive and maladaptive transactions between persons, and between the person and the environment, and conceives family problems not as diseases, but as reflective of environmental deficits. The reframing/relabeling technique emphasizes the positive aspects of behavior and redefines "negative" behaviors as positive when in accordance with cultural norms.**

Table 5 summarizes some norms that psychotherapeutic techniques responsive to cultural diversity must follow in any encounter.

ETHNOPSYCHOPHARMACOLOGY AND PHARMACOTHERAPY:

Pharmacogenetic research, or the study of genetically linked idiosyncratic drug responses, has highlighted **the central role of genetic factors in the metabolism of many of the psychotropic agents used today.[83] Ethnic differences appear to be related to polymorphic variations** (different forms of the same enzyme) **in the cytochrome P450** (CYP) **system. With a few exceptions, practically all psychotropic agents are metabolized by one or more of the CYP isoenzymes.[84]** Individuals possessing normally functioning polymorphic enzymes are called extensive metabolizers, whereas **those who manifest a substantially slower metabolic rate are poor metabolizers. Poor metabolizers of CYP 2D6 vary from less than 3% in Cuna Amerindians, those of Middle Eastern descent, Mexican Americans, and Asians to 10% in Caucasians of European and North American origin.[85,86] Although strongly controlled by genetic mechanisms, CYP 450 isoenzymes and conjugation enzymes are extremely responsive to exposure to environmental factors such as pharmaceutical agents, toxins, herbal medicines, steroid and sex hormones, constituents of tobacco, alcohol, caffeine, food ingredients, and dietary compositions.[84] Immigrants who change their lifestyles and exposure to these factors by virtue of their geographic relocation, also change substantially their metabolic profiles.** This has been demonstrated with Latinos living in the San Francisco Bay area.[87]

Table 5

CULTURAL GUIDELINES FOR PSYCHOTHERAPY WITH LATINO AND OTHER ETHNIC MINORITY GROUP PATIENTS

- Assess the importance of ethnicity and culture to patients and families.
- Validate and strengthen ethnic identity.
- Be aware of and use the patient's support systems.
- Serve as a "culture broker."
- Be aware of cultural "camouflage."
- Know that there are advantages and disadvantages in being of the same ethnic group as the patient.
- Avoid feeling that as a therapist one has to "know everything" about other ethnic groups.
- Avoid polarization, always trying to think in categories that allow for different possibilities in explaining clinical behaviors.

The activity of CYP 3A4 is significantly lower in Mexican Americans and Asian Indians than in other groups.[88] The reason is probably ethnic differences in dietary practices, especially the intake of certain vegetables that may inhibit the enzyme.[84,85] The use of cigarettes, alcohol, marijuana, and other substances appears to be rising among young Latino women; this may have significant effect on the metabolism of psychotropic drugs, since nicotine has complicating effects on multiple neurotransmitters (norepinephrine, dopamine, acetylcholine, serotonin)**, induces CYP 450 1A2 enzyme, and results in increased metabolism and decreased plasma concentration of phenothiazines, tricyclic antidepressants, and benzodiazepines. Similarly, coffee drinking through caffeine's sympathomemetic effects can worsen most mental illnesses and affect several cytochrome P450 enzymes.[88]**

In a recent study of more than 18 million office-based visits resulting in the diagnosis of depression in this country,[89,90] ethnicity was specifically explored. It was found that the use of antidepressant pharmacotherapy for any reason increased among non–Latino caucasians and African Americans but remained unchanged for Latinos during the study period (1994–1995). The rate of office-based visits documenting the utilization of antidepressants, a diagnosis of depressive disorder, or both was in the end comparable among African Americans and Latinos during the years of the study period, but was less than half the rate for whites in either time period examined.

Retrospective chart review studies of depressed Latino female outpatients found that they received half the dosage of tricyclics as Caucasian or African-American patients yet showed comparable treatment outcomes.[91–93] However, Latinos complained more often of side effects, and almost 20% discontinued the medication, a figure four times higher than that

of Caucasians. In fact, there are also discrepancies among different Latino subgroups' responses to tricyclic medications, as Puerto Ricans in New York, for instance, appear to be extremely sensitive to these types of medications.[92]

Sweeping generalizations at the present stage of research and knowledge in ethnopsychopharmacology should be avoided. Differences in findings may be related to epidemiological distinctions, environmental influences on mutation rates, pharmacogenetic variations, or cultural ("nonbiological") factors. Such factors include *insensitivity on the part of clinicians, which results in inaccuracies in diagnostic assessment and subsequent pharmacological mismanagement; prescriber bias, which often leads to women of color being overmedicated; expectations, adherence, or compliance patterns; and placebo response.*[87] Regarding Latino patients, Jacobsen and Comas-Diaz[88] point out the following additional factors:

- **Because of *familismo*, medications may be shared with relatives and significant others, practices that contribute to Latinos' risk of being overmedicated.**
- **Obtaining psychotropics from abroad is less stigmatizing than visiting a psychiatrist in the United States; pharmacists are key prescribers in Latin American countries, and their preparations are less expensive, a variety of medications can be obtained without prescription or professional supervision.**
- **Patients should be instructed to bring in all of the pill and herb containers the family has at home for careful inspection of labels and ingredients.**
- **The value that the Catholic Church places on the endurance of suffering and self-denial may discourage Latino patients from following-up on their pharmacotherapy.**
- **An overconcern by Latino patients about potential addictive consequences and toxic effects of psychotropics may lead to prolonged delays in starting treatment.**
- **When finally accepting medical interventions, Latinos seem to prefer oral rather than injectable administration routes, and expect rapid relief of symptoms.**
- **Latino patients' health-related behaviors may appear to contradict their deferential attitudes toward physicians. For example, regardless of the physician's instructions to the contrary, Latinos may take prescribed psychiatric medications on an as-needed basis, rather than on a continual basis, especially after a panic attack or the onset of depressive symptoms.**
- **Significant others need to be involved in Latino patients' treatment, not only to get information and participate in psychoeducational efforts, but also to preserve the significant intrafamily relationships common to this population group.**
- **A collaborative relationship in examining attitudes regarding racism, sexism, xenophobia, and elitism enhances the development of treatment plans, management of potential emergencies, and monitoring of side effects.**

Care Delivery System

Reaching Latinos in need of mental health care is one of the main components of the new policies on cultural competence.[94,95] Existing programs are trying to address policy, facility-institutional, and provider barriers by establishing new training programs, best practice guidelines, and modifying reimbursement practices.[5] Evidence-based treatments for adults with serious mental illness include **assertive community treatment to reduce readmissions of high-risk patients, supportive employment to teach job skills to patients, behavioral family treatment and cognitive therapy techniques, and illness management skills. All these approaches should be culturally and linguistically relevant for Latinos.** Governmental funding agencies, social scientists, and activist groups should converge to develop adequate planning and provide appropriate staffing and delivery of health services.[95]

Conclusion

Practitioners must learn from folk healers the respect and understanding that need to be given to the patient's cultural background. Employing spiritualistic conceptualizations for psychological problems, folk healers help to depathologize circumstances that are quite stressful for the patient. These practitioners are also readily available (especially during crises), will come for home visits, and are willing to provide services at nominal costs. They share a human relationship with their clients, based on respect, personal interaction, and trust. The end result is to make the patients feel comfortable and accepted, not stigmatized.[12,96]

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Questions Based On This Lesson

To earn CE credits, answer the following questions on your quiz response form.

33. Which one of the following statements is correct?

A. The health and mental health status of Hispanics improves greatly in the process of acculturation in the United States.

B. U.S.-born Mexican Americans have a much lower lifetime prevalence rate of major mental disorders than do Mexican immigrants.

C. Mexican-origin youth suffer from significantly more depression and suicidal ideation than Anglo-American and African-American youth.

D. The incidence of binge drinking or heavy use of alcohol is much lower among Latinos than in the general population.

34. The most powerful predictors of utilization of mental health services among the Hispanic population appear in those who are:

A. Diagnosed with schizophrenia.

B. Born in the United States and have more than one diagnosis.

C. Living in areas where there are a high number of Hispanic psychiatrists available.

D. Female, under thirty years of age, and gainfully employed.

35. In the treatment of Hispanic patients, it is important to:

A. Recognize how prideful they are and directly confront them with the inadvisability of holding onto such pride.

B. Point out from the outset that somatic accompaniments of depression, such as abdominal pain, have no basis in reality and refuse to discuss them further.

C. Assume a silent, uninvolved therapeutic stance in order to discourage any attempt on the patient's part to invest authority in the doctor.

D. Pay close attention to medication usage and be aware that the potential ineffectiveness of a medication may be related to ethnic variation in metabolism and/or cultural factors.

36. Which one of the following is *not* an aspect of therapy that should always be included in the therapeutic encounter?

A. Be aware of and use the patient's support systems (such as family, school, and church).

B. Make sure to appear knowledgeable about any ethnic minority you come in contact with; as a therapist it is important to inspire a sense of authority based on such knowledge.

C. At the inception of a therapeutic relationship the therapist should assess the importance of ethnicity and culture to patients and families.

D. Be aware of potential difficulties when the therapist is of a different gender than the Latino patient because pathogenic aspects of machismo and marianismo may be acted out in the therapeutic relationship.

Directions in Rehabilitation Counseling

Volume 12 Lesson 10

Developing the Case Management Relationship With Seriously Mentally Ill Homeless Individuals

Matthew J. Chinman, PhD, Peggy Bailey, LCSW,
Jennifer Frey, PhD, Michael Rowe, PhD

Dr. Chinman is Associate Behavioral Scientist, RAND and Health Science Specialist, VISN-22 Mental Illness Research and Clinical Center, West Los Angeles VA, Santa Monica, CA

Correspondence should be forwarded to Dr. Chinman:
RAND, 1700 Main Street, Santa Monica, CA 90407-2138
(310) 393-0411 x6783, chinman@rand.org

Peggy Bailey is Clinical Instructor, Department of Psychiatry, Yale School of Medicine and Director of Case Management Services, Connecticut Mental Health Center, New Haven, CT.

Dr. Frey is a Clinical Instructor, Department of Psychiatry, Yale School of Medicine, New Haven, CT, and Team Leader, Outreach and Engagement Team, ALSO-Cornerstone, Inc., New Haven, CT.

Dr. Rowe is Associate Clinical Professor, Department of Psychiatry, Yale School of Medicine & Resident Fellow, Institution for Social and Policy Studies, Yale University, New Haven, CT.

Introduction

Starting in the late 1970s, a number of factors contributed to what has been called a "new homelessness" in America; these include changes in the economy that affected poor people negatively, a loss of affordable housing, and, for people with disabilities, a lack of access to entitlement income.[1,2] In contrast to "old" homeless people (typically males over forty years of age living in isolated skid-row sections of American cities), "new" homeless people are younger, poorer because of a reduced capacity or opportunity to obtain and retain paid work, more visible, and more likely to be members of racial minorities.[3]

As with the "old" variety, "new" homelessness was characterized by disproportionate numbers of people with serious mental illness, due in part to the failure to provide adequate community-based public mental health treatment and related services for these individuals. In the mid-1980s the National Institute of Mental Health (NIMH) funded a series of rigorous epidemiological studies **that estimated a 20%–25% lifetime rate of serious mental illness among homeless single adults.[4–7] Koegel and colleagues,[8] using schizophrenia and affective disorders as the standard, estimate a 20%–23% rate of "severe and disabling" mental illness among the homeless. Estimates of the prevalence of dual diagnosis of mental illness and substance abuse among the contemporary homeless population range from 10% to 20%.[9]**

This lesson will focus on methods to be applied in outreach and treatment for the mentally ill homeless individual. After completing this lesson, the reader should be (1) familiar with some of the research on the prevalence of homelessness and serious mental illness, and the correlation between a strong case management relationship and outcomes; (2) knowledgeable about strategies that are useful in engaging homeless individuals who are mentally ill; and (3) able to identify factors which affect the development of the case management relationship.

What is Case Management and Why is it Helpful for Seriously Mentally Ill Homeless Individuals?

According to Willenbring and colleagues,[10] case management is a treatment approach that involves the following elements:

- **Identification of individuals who are not using mental health services and who would benefit from them**
- **Assessment to identify needs and strengths of the located individual**
- **Individualized treatment planning**
- **Linking clients to other needed services and supports**
- Ongoing monitoring to assess progress
- Advocacy or intervention on a client's behalf

Other services associated with case management may vary across programs and include the direct provision of clinical services for the client, crisis intervention, and intervening with organizations or larger systems of care in order to advocate for more effective, equitable and accountable services to a target group of clients. Several case management models have been used with homeless people suffering from a serious mental illness. Morse[11] summarizes the most common:

Intensive Case Management (ICM): **This is characterized by assertive and persistent outreach** (which often involves continuing to engage clients despite initial hesitancy, and doing so in their homes, on the streets, and in shelters) **with an emphasis on meeting individuals in their own environments and on their own terms.** Visits are made in a consistent manner, often over long periods of time, in an effort to gradually develop a relationship with the individual, within which services may be provided. Reduced case loads, and linkage of clients with needed resources are also chief components of Intensive Case Management.[12]

Assertive Community Treatment (ACT) and ***Continuous Treatment Teams*** (CTT): **These are characterized by an emphasis on providing treatment and services for clients** (often called "direct" service, as compared to referring clients to others for services); shared caseloads; and an interdisciplinary team that includes specialists such as psychiatrists, nurses, and social workers. Over the years, ACT has come to include a housing focus and assertive and persistent outreach. All of these features tend to be more helpful for homeless mentally ill clients.

Critical Time Interventions: **These are characterized by the strengthening of a client's long-term links to other services and supports while providing support during the transition to housing.[13]**

This lesson discusses ways to build and use relationships with clients by using a type of case management model that merges ICM and ACT/CTT models. **Morse[11] reviewed many research studies on the effectiveness of ICM and ACT/CTT case manage-**

ment models for use with seriously mentally ill homeless clients. Compared with either standard treatment or other more "hands off" models, such as brokered case management (which involves more referral and monitoring and less outreach or direct service)**, these models generally produce more positive outcomes, such as less time being homeless and more time in stable housing.**[14]

Research Summary on the Case Management Relationship:

The term "case manager" is used broadly here to refer to anyone who has the primary responsibility of providing services to a client and can include a range of professional disciplines. Many empirical studies have been conducted assessing various aspects of the relationship between case managers and homeless clients who have a serious mental illness. For example, **several studies have demonstrated increased service use among those who have a serious mental illness once a primary relationship has been established.**[15-17] **Empirical evidence also supports the connection between a stronger relationship or therapeutic alliance and better clinical outcomes for clients with serious mental illness,**[18-24] although the clients who are less functional seem to be less successful in establishing a therapeutic relationship in the first place.[25]

Two studies have specifically examined mentally ill clients who are also homeless. One study assessed 55 mentally ill homeless clients receiving services from a type of Assertive Community Treatment program[22] and found that clients with a higher alliance score after nine months showed more improvement on symptoms and social functioning at 18 months (temporally predictive relationship). Another study used data collected from 2,798 mentally ill homeless clients participating in a homeless outreach and case management national demonstration project called Access to Community Care and Effective Services and Supports (ACCESS).[26] This study also found a relationship between a stronger alliance and improvement in clinical outcomes.

Developing the Case Management Relationship

The remainder of the lesson is divided into three main sections: Engagement, Ongoing Clinical Work, and the Case Example. **There are many issues to be considered when providing case management services that are not addressed here, such as accessing natural supports, linkages to other systems and providers, ethics, and case manager safety.** However, the aspects of the case management work discussed here were chosen because they have a more primary relevance to the development of the case management relationship and the case management relationship itself is critical to these aspects of the work. In many cases, **it can be difficult to discern the difference between the work being done and the case management relationship as the two processes are often linked together in a perpetual cycle** (i.e., the "chicken or the egg" debate). Since it can be argued that all aspects of case management are related to the relationship developed between the case manager and client, it should be noted that the issues chosen are not meant to be exhaustive; rather, they represent selected ideas and skills that will be useful for case managers engaged in this type of work.

Engagement:

Outreach and Engagement

The criteria for entry into case management services typical of ACT/CTT/ICM are that the individual must have:

- **Severe and persistent mental illness and/or substance abuse**
- **Experienced barriers to engaging or sustaining involvement in mental health and/or substance abuse treatment (e.g., inability to keep traditional outpatient follow-up appointments)**
- **Multiple case management needs which cannot be adequately managed and/or coordinated either independently, with the support of a significant other, or within the context of traditional outpatient services**

Consistent with this lesson, the individual must also be homeless or at imminent risk of homelessness, which could mean (1) living on the street or in a shelter; (2) receiving notice-to-quit and/or eviction papers; (3) receiving notice to leave the home of a family member or significant other; or (4) transitioning between homelessness and publicly funded housing programs. Usually, **additional priority is given to individuals who cannot adequately manage a serious medical condition or individuals approaching release from incarceration or hospitalization with a history of serious difficulty in reestablishing needed services in the community.**

The first contact, and the beginning of the case-manager-client relationship, occurs in the context of providing outreach or engagement services. **A case management approach that addresses the basic needs of homeless mentally ill men and women has often been used to encourage these individuals to enter clinical services.** Frequent and consistent visits may be made to soup kitchens, shelters, and other areas that draw homeless individuals, and these individuals may be offered help in meeting their immediate needs for food, blankets, warm clothing, and emergency shelter. These initial community-based outreach efforts help to build an alliance that will support all aspects of the work later on.[27]

It is essential to note that there are significant differences between reaching out to homeless persons who may or may not be known to the local mental health system of care and providing services to individuals who are referred from other programs. In the case of the former, the initial engagement phase becomes much more critical. These individuals may be more difficult to engage due to a lack of familiarity with the mental health system (i.e., a lack of familiarity with the "rules" of treatment). They may view the engagement as more of a violation due to the intrusion of an outsider approaching their turf, and they may have lower motivation for treatment. **Therefore, assertive outreach to homeless individuals with mental illness explicitly involves the expectation that these individuals may reject case managers' offers of help at the outset. Furthermore, it is expected that many of these individuals will deny or try to conceal their mental illness.** However, case managers learn by experience and training to be keen observers of the individuals they meet on the streets. They are familiar with the symptoms of a psychiatric or substance abuse problem that may be openly observed through the homeless individual's behavior (e.g., responding to hallucinations, unusual speech, the smell of alcohol) or those that only become apparent in the course of starting a conversation (e.g., paranoia). While this lesson focuses primarily on the provision of case management services to individuals who are identified through outreach efforts, over time soup kitchen or shelter staff may direct the attention of case managers to particular individuals about whom they have concerns. These informal referrals may be generated about an individual who begins to display more overt psychiatric symptoms or who becomes a concern due to weight loss or other physical changes suggestive of a medical problem. **A potential client's initial reluctance does not place them at a lower priority for case managers than those who more readily agree to accept treatment and other services.** These individuals are, in fact, the focus of most homeless outreach programs, because in the absence of outreach efforts they are likely to remain underserved.

Assessment and Evaluation

Often intertwined with outreach and engagement, assessment and evaluation are important components of this beginning phase of case management, and may often begin through observation of the homeless individual. Through such interactions as bringing coffee to a person who has been observed enjoying coffee, case managers seek to understand what's important to the homeless person, and to use that information to tailor subsequent interventions. **Similar to outreach work, developing trust is important to facilitate the client's willingness to share concerns with the case manager. For example, return visits to an individual in a shelter may serve to nurture a caring relationship. Case managers also build trust by listening to the individual in a nonjudgmental manner, and by joining the homeless person in a collaborative exploration of his or her stated needs and the best ways of meeting those needs.** This can be difficult as case managers may understandably be struck by an individual's apparent need for housing or symptom stabilization. Housing or treatment may not be top priorities for a homeless person who has grown accustomed to life on the streets and who may have developed routines and a support network of other homeless people. **An agreement to tackle a goal that has particular importance to the client may be the gateway to the individual's agreeing to accept other services.**

Assessment and evaluation also includes recognizing medical or psychiatric emergencies that necessitate more aggressive interventions such as hospitalization. Assessment must include an examination of the following component's of the individual's lifestyle:

- Finances
- Physical health
- Vocational and educational issues
- Social supports
- Family relationships
- Transportation
- Spiritual needs
- History of arrests and/or incarcerations

Evaluating an individuals' history of drug or alcohol use is also important, including the existence of any family substance use or abuse. Equally essential, however, is the need to recognize the homeless individual as a person, and acknowledge individual strengths, abilities, preferences, and dreams.[28] Rather than indiscriminately offering services that may or may not be wanted or needed, working with an individual to meet stated needs, acknowledging the ingenuity and survival skills of the homeless person, and honoring his or her existing areas of competence strengthens the relationship. For example, a homeless man who moved into elderly housing after many years on the streets was assisted in addressing his loneliness and isolation by joining a singing group at a local non-clinical social support program, often call a psychosocial clubhouse. The case manager's awareness of this man's love for music and past involvement in a jazz ensemble facilitated the client's willingness to attend this singing group with her, reconnect with his considerable talent, and become a valued member of the group. Beginning efforts may be made to explore an individual's history from the standpoint of what has worked in the past, and what hasn't. For example, an expressed wish for housing or a job may serve as a springboard for further discussions about the client and about his or her past experiences in these areas.

It is important to note that **the engagement process may be a more prolonged endeavor with people who struggle with substance abuse in addition to mental illness and homelessness.** Both the literature and experience suggest that these dually-diagnosed individuals are more likely to have medical and legal problems, be isolated and estranged from their families, and also be more apt to resist help. These clients, as well as others who engage more tentatively or who refuse clinical services, may remain in the engagement level of case management for a longer period of time, ranging from several months to a year or more.

Boundaries

Traditionally, boundaries refer to the generally recognized ways in which mental health professionals in different settings maintain professional, rather than personal, relationships with their clients. While professional boundaries apply in any work setting, the boundaries that are appropriate for mental health clinics—formal dress, office settings, scheduled appointment times, and other factors—cannot be maintained in the same form on the streets or in emergency shelters if the clinician hopes to gain the trust of the homeless person. Therefore, **going beyond these traditional clinical boundaries and bearing witness to each client's unique experience of homelessness greatly enhances the mental health professionals assessment and understanding of the individual.**

However, immersion in the environment of homelessness also serves as a challenge to these professional boundaries. Experiences ranging from witnessing the abject poverty of homelessness, to the undertaking of tasks such as doing laundry or moving a homeless individual into a new apartment may rouse discomfort in the case manager, as well as in the homeless person, both of whom may be aware of the disparities between their life experiences. This discomfort associated is generally less pronounced in the context of office-based work, where deprivations are spoken of but rarely witnessed, and where the life circumstances of the client remain far more private. **As a result, case managers may struggle with a range of inappropriate desires from unrealistic fantasies of "rescuing" their homeless clients to personally providing them with clothes and money outside the context of the outreach program.**

The boundary between a client and case manager is further complicated by a homeless person's often unpredictable schedule or choosing to be "found" only in the context of a crowded soup kitchen or shelter. From the perspective of the homeless person, this may afford a measure of privacy from the intrusions of the case manager. However, from the worker's standpoint, the lack of privacy affects the issues that may reasonably be addressed and the pace of the work. The establishment of a relationship between the case manager and the homeless person is made possible only through balancing the homeless person's need for privacy and the ability of the worker to respect that trust increases over time. For example, waiting to be invited to approach public or open structures (e.g., park benches, corners of parking garages, a shelter bed) currently occupied by homeless individuals shows a respect for privacy often absent from the lives of those who are homeless and have a mental illness. This "construction" of boundaries with individual homeless clients, while simultaneously breaking the boundaries of traditional treatment, promotes trust and the development of a genuine, respectful relationship.[29]

Ongoing Clinical Work:

Medication and Symptom Management

Discussions about medication serve as a common arena for negotiation in work with homeless individuals who also struggle with mental illness. Case managers may view reluctance to consider medication as resistance or noncompliance. However, there is some indication that the client may be more inclined to accept medication recommendations if he or she feels understood as a person in the relationship with the case manager.[30] **Partial compliance may evolve toward full compliance if serious consideration is given to any concerns that the homeless individual associates with the prescribed medication. This negotiation may not only be beneficial in terms of treatment, but also can serve to strengthen the relationship.**

The case manager may facilitate the acceptance of medication or other recommended services in a number of ways, perhaps most importantly by being available to accompany the client to appointments that might otherwise be avoided. The case manager's knowledge of the client helps determine the type of assistance needed. Some clients may only need or want a ride, others may benefit if the case manager accompanies them in the waiting area of the service agency or medical office, and yet others may need the case manager to be a more active participant. For instance, the client may need assistance from the case manager in voicing their concerns to other service providers or may make more progress if procedures or recommendations are reviewed afterward. In this manner, the homeless individual can learn from the case manager to ask questions, negotiate conflicts, and, ultimately, to more fully participate in his or her own care. For example, an episodically homeless man with a severe psychotic disorder generally sought medical attention at a busy public clinic; however, he did not understand the protocol of informing clinic staff of his arrival for an appointment. Thus he often spent several hours at the clinic without being seen by the medical staff. When he was seen, he would describe his symptoms in very unusual ways, complaining that he had an elephant bone behind his ear or a BB pellet bouncing between his belly and his head. Only after his case manager had become familiar with his complaints and had begun to accompany him to his appointments with his doctor were his symptoms appropriately diagnosed and treated as indications of cardiac disease.

Issues Specific to Substance Abuse Treatment

We take the position that substance abuse treatment is linked to case management for homeless clients with a serious mental illness.[31] As noted earlier, clients with substance abuse problems are more apt to resist help, and may remain in the engagement level of case management for several months to a year or more. With its emphasis on making interventions when they will be most welcome, substance abuse treatment techniques such as ***Motivational Interviewing*** (MI) are particularly helpful in developing the case management relationship and pacing work with the client during this time. MI is an empathic, supportive and directive counseling style. The alliance between case manager and client is a collaborative partnership to which both parties bring expertise. **Ambivalence about substance use and change is viewed as normal and as an obstacle to recovery that can be resolved by working with the client's intrinsic motivations and values.** For example, if the case manager uses reflective listening or accurate empathy, the client knows that his or her agenda is understood. **Through the MI process, the client begins to question his or her assumptions about the harmlessness of his or her substance abuse patterns.[32] At this point, case management personnel have the opportunity to begin identifying the client's interests and needs (e.g., health insurance, treatment, employment, housing, special talents). Once the client and the case management personnel arrive at a shared understanding of how substance abuse causes the client's current life to differ from the life he or she wants, it's possible to assess the client's confidence and ability to change.[33]** MI assists the case manager in maintaining awareness of the many changes in motivation the client may experience and in further engaging the client to remain in treatment.[34]

Housing

Experience has taught us that the client's degree of clinical stability, readiness for housing, and their negative or troubling associations with "home" (e.g., previous inability to maintain an apartment or conflict that led to estrangement from the family home, etc.) can be important considerations in preparing individuals for the practical and emotional transition from homelessness to housing.[35] **It is important that case managers maintain a consistent and supportive relationship with their clients during this difficult transitional period, and that they continue to support their clients after they have been housed. This not only involves working concretely with clients to ensure that they remain housed (i.e., ideally using a more skills-focused approach, including house maintenance, food shopping, paying bills, etc.), but also includes discussions about the development of a new "housed" identity (e.g., creating new social networks, taking part in community life, thinking about work, etc.).**

Treatment Planning

Often, with this population, case managers are confronted with the dilemma of benevolently wanting to "fix" their clients' many problems, and working on what the client identifies as their needs and wants may not appear important or relevant. Consistent with what was stated in the section on engagement, this model of case management attempts to plan treatment collaboratively in the context of a strong relationship between the case manager and client. **Collaborative treatment planning involves empowering clients to take responsibility for their own recovery; this represents a substantial departure from conventional models of treatment in which clients are relatively passive and rely on the expertise of providers to set treatment goals. Preliminary evidence[36] shows that clinicians often underestimate client willingness and ability to participate in the treatment planning process, even when clients are in fact willing and able.** Therefore, case managers need to adopt a different philosophy about letting clients participate equally in the treatment planning process. For example, case managers may need to reconceptualize clients' behaviors (e.g., what may appear to be disinterest may be fear that the client's suggestions will be rejected) in light of the data that demonstrates high client interest, and take extra steps to provide genuine opportunities for participation. Emphasizing equality between clients and case managers in the treatment planning process reinforces mutual trust and understanding, which can also assist in the development of a strong case management relationship.

Promoting Social Integration

The case manager has close ties to all aspects of a client's life and is in a unique position not only to solve problems and resolve crises, but also to promote social integration. In this case, promoting social integration involves assisting homeless or formerly homeless people with mental illness to gain access to all aspects of community life from which they have been removed because of their illness, their impoverished social and economic situation, and the stigma that they face. This is in stark contrast to the prevailing view that people with mental illness must be "stable" before their reentry into the community.[37,38] **Helping clients become**

more socially connected often reduces stress,[39] can act as a "buffer" against the development of illness,[40] and is associated with greater community tenure.[41]

The unique aspects of the case management model described in this lesson (e.g., more equal relationship, less rigid boundaries, focus on client strengths and desires, allowing the client to participate in the treatment planning, etc.) are exactly what places the case manager in an excellent position to promote social integration. For example, signing-up and attending a cooking class with a client who may be hesitant at first demonstrates how a strong relationship and social integration are related. The case manager's knowledge of a client's interest in cooking, their willingness to attend a class with that client, the client's trust in the case manager needed to get involved in this new activity, and the "thinner" boundaries that allow them to attend a primarily social activity together are all aspects of the relationship that facilitates this type of work. Promoting social integration is primarily meant to help clients develop new connections in the community, yet the very nature of these activities serves to strengthen the case manager relationship as well.

Case Example

This case example demonstrates the value of the themes discussed above in the case management of a client struggling with homelessness, mental illness, and substance abuse. The case management service, called the "O & E Team" (for Outreach and Engagement), is a hybrid of the ICM and ACT/CTT models described above and is specifically designed for individuals who are homeless and mentally ill. The O& E Team is a division of the Connecticut Mental Health Center (CMHC), located in New Haven, CT and funded by the State Department of Mental Health and Addiction Services. The team is a collaboration between the CMHC and several local residential, vocational, and social rehabilitation agencies and homeless shelters. It is made up of psychologists, social workers, nurses, and mental health workers, each of whom have a caseload of 15 to 20 clients at any one time. A client is followed by a part-time psychiatrist and assigned one of the team members who is primarily responsible for most of the administrative duties and has the most authority over the client's clinical care. Since it is still a team environment, however, there is a good deal of "client sharing" in which staff other than the primary clinician work with the client.

Work with a homeless individual generally commences in one of two ways: O&E case managers may make contact with a previously unknown individual in the course of their outreach rounds or they may receive a referral from shelter or soup kitchen staff, or from another service provider asking them to assess an individual. They will attempt to make contact with the client and will provide a range of services including, but not limited to, assistance with social service agencies, medication management, housing, employment, family issues, coping skills needed to enhance their tenure in the community, and preparations for entry into longer-term outpatient care. The following case example summarizes one client's experiences, it is divided into three sections: before receiving services from the O & E case managers, the client's life while receiving these services, and current status.

Nelson*—A Client's Life Before the O & E Team:

* Name has been changed to preserve confidentiality

As is often true with those who are homeless, mentally ill, and substance abusers, many of the details of Nelson's early life are unclear. This not only speaks to Nelson's own uncertain memory, but also to his disconnection from all aspects of community life.

> **Nelson is a white male in his early 50s. Born and raised in New Haven, CT, he was one of the youngest of 10 children. He reports that his father was a severe alcoholic who was verbally and physically abusive and is now deceased. His mother lives in a nursing home. He remembers growing up in an apartment above a pizza shop and washing the dishes, as his older siblings had done before him. He reports being a poor student in high school, but he did attend college, dropping out after one to two years following a break up with a girlfriend. After college, he joined a house-painting business run by his**

brothers, but, according to Nelson, the business dissolved near the time that he was arrested for arson.

Nelson received a diagnosis of Bipolar Disorder during his first hospitalization, probably in his early 20s, after the breakup with his girlfriend. He reports being severely depressed at that time and possibly attempting suicide by overdose. He was hospitalized about 5 times a year from 1997 to 2000, with a total of more than 50 hospitalizations during his lifetime. Typically, his hospitalizations have been precipitated by alcohol and/or crack or marijuana use, and the subsequent exacerbation of his manic symptoms (e.g., walking into traffic or screaming in a local bank). In 1999, while exhibiting such symptoms, he was charged with sexual assault stemming from the nonconsensual touching of a woman. He spent two months in jail; shortly after being released he was admitted to a psychiatric inpatient floor with symptoms of irritability, verbal aggression, and sexual inappropriateness. Nelson has been charged frequently with minor offenses such as breach of peace and criminal trespassing. He is well known to the local police, not only because of these difficulties, but because he grew up with many of them. In fact, the police tried to help Nelson when he became more ill by taking him to the hospital and contacting his public defender. Nelson lived at home with his parents until he was about 35, and since then he has not lived anywhere consistently for more than 6 months. He has tried sober houses twice without success and all of his attempts at independent living have resulted in substance use and an exacerbation of his manic symptoms within months. In January, 2000 the inpatient staff of the local psychiatric hospital referred him to the O & E team. The referral indicated that he was pending sentencing on the sexual assault charge. At the time of his referral he exhibited symptoms of mania and delusions about the FBI.

Client's Life During O & E:

At the first meeting with case management staff from the O & E team, Nelson described his employment history as a house painter and his wish to return to that vocation. He described himself as an alcoholic who liked to attend Alcohol Anonymous groups and admitted to having been "a little manic-y" before hospitalization. Nelson requested assistance getting into a housing program that would pay his rent. In the next meeting on the inpatient ward he accepted some clothing, and denied that he had ever been "manic-y." Although he dismissed concerns about his pending legal situation, he did agree to let case management staff speak to his public defender and refer him to substance abuse treatment programs.

While Nelson was on the inpatient unit, case management staff requested that Nelson be referred to neuropsychological testing due to concern that he seemed to have no memory of the previous meeting or substantial parts of his own history. The testing sessions were discontinued after 10 minutes because Nelson became extremely agitated. Over the next few days, he contacted case management staff repeatedly to inquire about when he would be discharged from the inpatient unit. Although it was agreed that he would attend an inpatient substance abuse treatment facility, most programs rejected his application because he was dually diagnosed and had a pending sexual assault charge. Acknowledging that Nelson's psychiatric record shows he appears disproportionately threatening, case management staff called one of the programs to advocate for his acceptance by presenting an account of Nelson's more recent appropriate behavior on the inpatient unit, and the program then agreed to accept him.

However, during this period, Nelson became discouraged with waiting for the substance abuse program and instead wanted to live in a rooming house with the landlord serving as the payee (a person who will receive or manage the clients money) for his disability funds. **At this point it became necessary to act quickly and respond to Nelson's concerns while being careful not to alienate him. Expressing the desire to understand his intentions, case management staff engaged Nelson in an open discussion about what he perceived to be the advantages and disadvantages of his plan. Case management staff also voiced to Nelson the**

real possibility that he could serve jail time for his most recent offense and reassured him that case management staff would follow him through the treatment program and help with problems as they arose. The next day he entered the treatment program and, during this stay, case management staff made weekly phone calls and visited him monthly. Nelson relied on case management staff to accompany him to court and to describe to the Public Defender, prosecutor, and judge, his efforts to engage in treatment and find housing. Nelson currently has 3 years probation and willingly admits that his legal situation is the reason he engaged in the treatment plan.

At first, Nelson refused to attend all the required groups at the substance abuse program. He became argumentative when encouraged to attend groups and explained that "the groups aren't run right—they go on too long." During a visit with case management staff he vehemently denied that he was getting into arguments, but agreed he could walk away from a provocative situation. He then attended all of his groups and, for the remainder of his 5 months in that program, he complied with treatment. Nelson graduated from the program and is currently engaged in a Dual Diagnosis Supportive Housing Program. **After this transition, he stated that staff follow-through was helpful in managing these changes, "You follow through with what you say. You people have a lot of plans." When asked if he felt he had some say in the plans, he simultaneously expressed his dislike for the "ground rules" of the intensive case management service and his trust in and appreciation of a relationship that allowed him to disagree with staff: "Do I have a say in the plans? Not all the time, but I don't always have the best ideas."**

Current Status:

Despite a difficult transition, Nelson has currently spent 11 months in the Dual Diagnosis Supportive Housing Program and has been sober for 16 months. A visiting nurse brings him medication two times a day and he is medication compliant. Although one day program discharged him after 3 weeks (because he was sleeping during group sessions), he currently attends Alcoholics Anonymous groups four times a week, has an AA sponsor, and successfully graduated from a second dual diagnosis partial hospital day program that is well suited to treat clients who are dually diagnosed and have been homeless. He agreed to attend the second day program after case management staff consulted with a friend who assured Nelson that they could still work together in the friend's business. He completed neuropsychological testing which showed strengths in math skills and weaknesses in spatial relations and memory. He was referred for vocational services, has a part-time job, and occasionally paints houses. However, he still reports trouble with "motivation" (what he calls getting out of bed) on the mornings he doesn't have to go to work. With the support of his case manager, he has improved his relationship with his brother and he visits his mother regularly.

Case managers can often help clients repair strained relationships with family and friends. Family members often place high value on communication with a case manager who can provide information about how the homeless person is managing, and who will listen to the concerns that may have driven the client and family apart in the past. Over time, the case manager may be able to facilitate more direct contact between the client and family; and assist them in working through the challenges in their relationship.

Case Summary and Conclusions

Highlighting the themes that emerge from this case example also serves to summarize the issues discussed above. For example, O & E's early engagement through giving material goods, using MI skills, and persistent and consistent follow-through helped strengthen the case manager's relationship with Nelson, which facilitated his involvement in treatment. As Nelson became more involved in treatment and made gains, the relationship was further strengthened as he came to understand that the case management staff could be relied upon and trusted to provide useful assistance. Also, the flexibility of the case management staff's boundaries is particularly evident in this case as Nelson moved through different treatment systems (e.g., psychiatric, legal, substance abuse, and residential treatment facilities). Nelson's specific strengths and individuality were exemplified by his survival skills, desire to stay out of prison, independence, desire to work, interest in forging a relationship with his family, and ability to adjust to the expectations of many systems. **By approaching Nelson as an expert in these areas, in addition to taking into account his material needs, the case manager was able to collaborate with him in crafting a viable treatment plan. Similarly, a sensitive and flexible appreciation of the client's need and attempts to reconnect with community support systems forms the basis of the client's transition to greater independence and satisfaction.**

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Questions Based On This Lesson

To earn CE credits, answer the following questions on your quiz response form.

37. What is the lifetime prevalence rate for mental illness among homeless single adults?

A. 1%–2%

B. 10%

C. 20%–25%

D. 35%

38. Which one of the following statements about research on those who are homeless and mentally ill is *not* correct?

A. Studies have indicated that having a relationship with a case manager is linked to increased service use among those who are homeless and mentally ill.

B. Studies have shown a correlation between a strong alliance between case managers and their homeless mentally ill clients and improved clinical outcomes.

C. A review of several studies showed that the Brokered Model of case management was the most effective for those who are homeless and mentally ill.

D. There is some evidence that case managers and mental health professionals underestimate the ability and willingness of mentally ill clients to engage in collaborative treatment planning.

39. You have been assigned to engage an individual who is homeless, mentally ill, and known to be a substance abuser. While driving around town, you spot him sitting on a bench in the town square. As this is your first meeting, what would be the best first course of action?

A. Conduct a thorough assessment.

B. Offer him substance abuse treatment.

C. Introduce yourself as his new case manager.

D. Offer him a cup of coffee.

40. Working with clients who are homeless and mentally ill often requires stretching the clinical boundaries beyond what is common in traditional office-based treatment. Which one of the following would still be considered a boundary violation?

A. Taking a client food shopping.

B. Giving a client money.

C. Stopping to talk to a client in public after she has engaged you in conversation.

D. Giving a client a ride to a social service agency.

Directions in Rehabilitation Counseling
Volume 12 Lesson 11

Meeting the Psychosocial Needs of Burn Survivors and Their Families

Shelley A. Wiechman, PhD, David R. Patterson, PhD

Dr. Wiechman is a Postdoctoral Fellow, Department of Rehabilitation Medicine, University of Washington School of Medicine, Seattle, WA.

Dr. Patterson is a Professor at the Department of Rehabilitation Medicine, University of Washington School of Medicine, Seattle, WA.

Introduction

Burn injuries are a common form of trauma in the United States, surpassed only by motor vehicle accidents, falls, and drownings.[1,2] Burn injuries account for an estimated 70,000 hospitalizations annually (40,000 of these hospitalizations are children or adolescents), and 5,500 deaths in the United States alone.[2,3] Demographics from U.S. burn centers show that the etiology of a burn injury is related to age. The most common type of burn injury is a scald burn, with children, the elderly, and the disabled being most prone to this type of injury (see Table 1). Male adolescents are most prone to suffer a burn injury due to risk-taking behaviors, such as playing with fireworks or gasoline. Certain occupations are at more risk for burn injuries, including electricians and workers in the food-service, chemical, or fuel industry.[2]

In the last 10 years, great advances have been made in the area of the successful physiological recovery of burn patients, which has significantly increased their survival rate. Unfortunately, research on the psychological needs of individuals who survive burn injuries has lagged behind and continues to receive inadequate attention. It is promising, however, that many burn centers employ social workers, vocational counselors, and psychologists as part of the burn team. This lesson will summarize the research on the psychosocial outcomes of patients with burn injuries and offer guidelines for working with burn patients to meet their psychological needs. After studying this lesson, the reader will have a greater understanding of the psychological needs of patients with burn injuries at various stages of their recovery and the available treatment options at each stage.

The size of a burn injury is expressed as a percentage of the total body surface area. Wound depth is determined by the elements of the skin that have been damaged or destroyed. **Two broad categories are used to describe depth of injury: partial-thickness burns and full-thickness burns. Partial-thickness burns are hypersensitive and can be more painful than deeper full-thickness burns. Burn pain severity does not correlate with the size or depth of the burn.**[4] Patients with superficial burns, as well as those with full-thickness burns, report high levels of pain.

Hospitalization for burn injuries may vary in length from less than one week to several months, depending on the severity of the burn and the presence of other medical complications. A general rule of thumb for length of stay in a previously healthy patient is one day for every 1% of **total body surface area** (TBSA) burned. Of course, this is affected by any complications such as failing grafts or infections. **Physiologic recovery of a burn patient is seen as a continual process that can be divided into three stages: (1) resuscitative/critical, (2) acute, and (3) long-term outpatient rehabilitation.**[2] Each stage has a distinct medical, environmental, and physical context and presents the patient with a unique set of challenges. For clarity, the discussion of the psychological needs of burn patients will follow these three stages.

Resuscitative/Critical Stage

Issues:

Severe burn injuries are almost always treated in surgical departments and, preferably, in multidisciplinary burn centers. The resuscitative phase typically lasts up to 72 hours after the burn injury and involves maintaining fluid balance, removing dead skin, and preventing topical infection. Patients are usually treated in the intensive care unit (ICU) during both the resuscitative and critical phase and may stay in the ICU for weeks. **Characteristic issues in these initial stages include stressors of the ICU environment, uncertainty regarding outcome, and the struggle for survival.** The environment of the ICU can be both overstimulating with its bright lights, machines, and multiple health care providers, and understimulating with the monotony of lying in a hospital bed, often immobile for weeks at a time.

Table 1
MOST COMMON TYPES OF BURN INJURY BY AGE GROUP

Age Group	Common Burn Injuries
0–4 years	• Scalds (spill or bath related) • Residential fires • Household chemicals (topical application or ingestion) • Household electrical injuries (electrical cord bites)
5–14 years	• Residential fires • Risk-taking behaviors (fireworks, fire-setting)
15–24 years	• Automobile associated • Work related
25-64 years	• Work related
>65 years	• Scalds • Careless smoking • Cooking accidents

From: Rutan, RL. Physiologic response to cutaneous burn injury. In: Carrougher GJ, ed. *Burn Care and Therapy*. St. Louis: Mosby; 1998:1–33.

Cognitive changes such as extreme drowsiness, confusion, and disorientation are common during this phase. More severe cognitive changes such as delirium and brief psychotic reactions also occur. These cognitive changes may be symptoms of infections, alcohol withdrawal, metabolic complications, and effects of high doses of medications. Many patients report that they do not remember this phase of their treatment. Patients may also be intubated (passage of an oro- or nasotracheal tube for anesthesia or control of pulmonary ventilation), which substantially limits direct communication.

Treatment:

In-depth psychological intervention during this phase is of minimal value. Even if patients do become more alert, focusing on past or future concerns may be counterproductive; the patient's pri-

mary task during this phase is physical survival. Directly confronting issues related to the causes or ramifications of the injury can easily overwhelm coping resources that are needed for survival. Due to the patient's fluctuating mental status, it is futile to try and teach new coping strategies at this phase. **The clinician should protect coping strategies that the patient is already using; patients should be encouraged to cope with the frighteningly unusual circumstances of the ICU through whatever defenses are available, even primitive strategies such as denial and repression. Supportive psychological interventions should focus on immediate concerns, such as pain control and inspiring hope in the patient.**

Medical staff can also effectively intervene during this early stage of recovery by working with the patient's family members. Understandably, family members may be anxious and distressed while observing the patient undergo treatment.[5] **The patient's coping ability is often influenced by cues received from significant others.** The presence of family members and friends can promote a sense of familiarity in patients and can alleviate anxiety and agitation. However, family members should be encouraged to intervene in a supportive and limited manner. **As family members express high levels of anxiety and stress, the patient may pick up on these cues and behave accordingly. It is important to help family members understand this effect and help them to convey a sense of hope and calmness that will encourage the patient to reflect these emotions.**

Intervention, including education and emotional support, might also be directed at the staff during this phase of recovery. Educational support may include helping staff to distinguish between distress and the syndrome of depression in the patient, and helping them understand the transient nature of delirium. Further, it is common for medical staff to feel helpless and question their adequacy in the face of uncertain physical status. They may then project these feelings onto the patient. Providing support to staff members and helping them to understand and deal effectively with these issues can help them to monitor and gain insight into these potentially counterproductive reactions.[6]

Acute Stage

The acute phase of rehabilitation begins after capillary integrity has been restored and diuresis (excretion of urine) has begun.[7] **This phase of recovery focuses on restorative care and includes nutritional support, excision and grafting, and topical wound care.** As cognition improves and patients become more alert during this phase, they are faced with very painful procedures, often with less sedation. Although patients are moved off of the ICU and to an environment that is more consistent and less intrusive, they still must undergo painful treatments. For example, it is the practice of many burn centers to debride (excise devitalized tissue and foreign matter from wound) burned skin on a daily or twice-daily basis. Burn injuries that lack potential to heal on their own are treated with skin grafts. Physical and occupational therapy is an important part of this phase to help prevent scarring, maintain functional range of motion, and prevent overall deterioration of bodily organs from sustained hospitalization. The intense, daily physical rehabilitation that includes range-of-motion exercises and splinting can be an additional source of pain and anxiety. Finally, as patients become more alert and oriented during this phase of recovery, they are more aware of the physical and psychosocial impact of their injuries.

Sleep Disturbance:

A common complaint of hospitalized patients is sleep disturbance. The environment can be loud, patients are awakened periodically throughout the night to have pain medication administered or to have vital signs taken, and a patient's mood and/or levels of anxiety can affect sleep. **Nightmares are common sources of sleep disturbance and can be due to pain medications or a result of the trauma itself. Sleep deprivation can lead to higher subjective pain ratings and a decrease in mood; therefore, it is important to treat this symptom.** Informing patients that dreams are normal and typically subside in about a month can help allay concerns of abnormality and refocus patients' mental energy on other areas of recovery. Medication and relaxation techniques may also help with sleep disturbance.[8,9] Common medications include temazepam

(Restoril), zolpidem (Ambien) and trazodone (Desyrel). A consult with the psychiatry service should be obtained for medication recommendations.

Psychiatric Disorders:

Distress is common among many patients hospitalized for burn injuries, but symptoms do not often reach diagnostically significant levels. Symptoms of both depression and anxiety start to appear in the acute phase of recovery. Rates of depression and generalized anxiety are similar to those found in other hospitalized patients; however, acute stress disorder (ASD) and post-traumatic stress disorder (PTSD) occur more frequently in burn patients than in other patients.[10] The literature includes estimates of moderate depression ranging form 23%–61%, general anxiety from 13%–47%, and PTSD at 30%.[1] Unfortunately, methodological problems with these studies limit the conclusions that can be drawn. For example, researchers studying depression have not usually distinguished between a clinical diagnosis of depression and depressive symptoms. **Typically, the burn patient's average self-reported symptoms fall in the mildly depressed range.** This is not surprising given the number of physiological symptoms required in the assessment of depression. Many burn patients do not meet formal criteria for a diagnosis of depression since their symptoms may not have been present for more than two weeks, and because it can be difficult to assess many of the symptoms in the hospital setting (i.e. finding enjoyment in activities). **It is important that symptoms of depression are treated (behaviorally or pharmacologically), even if the patient fails to meet all criteria for a diagnosis of depression.**

Researchers have identified certain conditions in which depression is more likely to occur. **One study found that hospitalization for more than 1 month, along with repeated medical setbacks, was associated with increased depression.** [11] **The severity of depressive episodes has also been related to a patient's level of resting pain.**[12] **Finally, a premorbid history of depression can also lead to an increased risk of depression during hospitalization.**

Studies of anxiety disorders are more methodologically sound and have distinguished between general anxiety, PTSD, and, most recently, ASD. The incidence of general anxiety among burn patients seems to be comparable to that found among other medical and surgical patients, and seems to decrease over time (50% prevalence at week 1 to 13% prevalence at week 4).[1] **Patients experiencing PTSD typically have larger burns, more severe pain, and expressed more guilt about the precipitating event.** In a study of 54 consecutively admitted burn patients assessed for PTSD, 63% of patients reported intrusive, recurrent memories of the burn event, but only 30% met full criteria for PTSD.[13] This suggests that replaying the traumatic event in one's mind is a common method of processing the trauma, and does not necessarily lead to a diagnosis of PTSD. More recently, a series of studies found similar rates of ASD (inpatient) and PTSD (outpatient).[14,15] One study found an actual increase in PTSD as time progresses after hospitalization, from 35% at 2 months after discharge to 40% at 6 months after discharge, and 45% at 12 months after discharge.[16] **Again, it is important not to overlook subclinical symptoms of posttraumatic stress in patients who do not meet full criteria for the disorder as the symptoms are causing distress for the patient and can inhibit recovery.**

Treating Psychiatric Disorders

Clinical depression is not common, but it is important to treat subclinical symptoms of distress and depression. Brief, supportive counseling may be helpful, but medications may also be necessary. **When offering counseling to a patient, it is often helpful to normalize the patient's depressive symptoms and provide reassurance that symptoms often diminish on their own, particularly if the patient has no premorbid history of depression.** Common classes of medications used to treat depression are the selective-serotonin reuptake inhibitors (SSRIs). If a clinician feels that a medication may be helpful they should consult the psychiatry service.

Posttraumatic stress symptoms can be thought of as a predictable psychological response to the abnormal stress of the burn injury. PTSD following the abnormal stress of an assault has been treated successfully; Foa, Hearst-Ikeda, and Perry[17] found a brief intervention program with treatment that included exposure, relaxation training, and cognitive restructuring to be effective in reducing PTSD symptoms in women who had been assaulted. The authors attributed treatment success to instituting treatment two weeks post-trauma rather than immediately after the trauma. There has been no research to date on the effectiveness of this type of intervention on PTSD in burn patients. **Yet, waiting several weeks after the trauma to institute any interventions, which should take place after a patient has stabilized medically; is a good idea with burn survivors as well. Treatment may need to be undertaken when the burn survivor is an outpatient.**

We have found that **an effective initial approach involves normalizing symptoms for patients, helping them talk through the events repeatedly, and providing the opportunity for confronting, rather than avoiding, reminders of the trauma.** Social support is also an important factor in treatment for ASD symptoms. Often, just knowing that there is someone to talk with about the accident may be enough to help the symptoms subside. An approach combining normalizing symptoms and education may be the most effective treatment for many patients initially, but a combined counseling[17] and medication treatment approach is helpful when symptoms do not abate after a short period. SSRI's have been shown to be effective for the treatment of both depression and anxiety. The implementation of medication should be a joint decision between the patient, counselor, and psychiatry service.

Premorbid Psychopathology:

Recent studies which focused on the issue of premorbid psychopathology in patients with burn injuries **show that the incidence of mental illness and personality disorders is higher in burn patients than in the general population.**[1,18,19] Incidence of prior psychiatric disorders is estimated to be from 28% to 75%; the most common diagnoses identified in these studies include depression, personality disorders, and substance abuse. These studies also document several ways in which **prior psychopathology has an adverse impact on hospital course, including longer lengths of hospitalizations and the development of more serious psychopathology after a burn injury. Individuals with preexisting psychopathology typically cope with hospitalization through previously established dysfunctional and disruptive patterns. The burn unit staff often makes the mistake of trying to treat a patient's premorbid psychopathology during hospitalization. Certainly Axis I disorders such as depression can be treated as an inpatient if symptoms are causing distress for the patient; however, more complex disorders such as substance abuse and personality disorders cannot be treated during the inpatient stay. Referrals to community treatment programs should be made once the patient is ready for discharge to prevent the exacerbation of these disorders once the patient returns home. In the case of personality disorders, the only effective inpatient intervention is to create a detailed behavioral plan to manage any behavioral problems.** For example, avoid opportunities for the patient to split staff by designating a person to communicate the treatment plan with the patient. Set clear behavioral expectations for the patient and inform them of consequences for violating these expectations (e.g. no smoking privileges if the patient uses profanity with a nurse). Encourage nursing staff to ignore inappropriate behavior by leaving the patient's room, and to reinforce any positive behaviors.

Grieving:

A patient may also begin the grieving process at this phase and become more aware of the impact of the burn injuries on his or her life. A family member, friend, or pet may have died in the accident. A patient may also have to cope with the loss of their home or personal property. In addition to these external losses, the patient may also grieve for the loss of the former life (e.g., job, mobility, physical ability, appearance). A recent article[20] dispels common myths about coping with loss. It is important that mental health professionals and other staff respect this grieving process and help the patient to grieve in their own way and at their own pace. Social support is important during this time; not all patients will want to talk about their grief, but counselors can offer their service and let the patients choose their preferred coping strategies. The hospital chaplain may also be helpful during this time.

Pain Control During the Acute Stage

Sustaining a severe burn is one of the most painful

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experiences a person may have, yet typical burn care inflicts more pain than the initial trauma. Once or twice daily, patients have their dressings removed, necrotic skin debrided, and antiseptic agents applied. This process may continue for weeks or months. Ptacek, Patterson, and Doctor[21] indicated that the pain reported by a patient varies substantially from day to day, does not follow a uniform pattern between individuals, and is not related to the size of the burn injury. **Burn patients experience two distinct types of pain: background pain and procedural pain.** Background pain is experienced while at rest; it is more of a continuous, long-acting pain. Procedural pain is experienced during a medical procedure and is greater in intensity and shorter in duration. Patients report that procedural pain is excruciating, despite receiving morphine during wound care.[22] Interestingly, some patients report that procedural pain is easier to cope with because of its transient nature. Background pain, however, can tax coping resources because there is no clear end in sight.

Assessment:

Appropriate assessment of pain is the first step to providing adequate pain control. The methods of measuring pain can be physiological, behavioral, or by self-report. Physiological parameters include heart rate, blood pressure, respiratory rate, and oxygen saturation. Although it can be difficult to ascertain the relationship between these parameters and level of pain, they can be useful for assessing pain in patients who are not able to communicate with staff. Behavioral measures include crying or grabbing the wound. Self-report measures enable patients to indicate their pain level and can be in the form of numbers, pictures, or questionnaires. No single measure is adequate to use with patients of all ages, so it is nice to have a wide range of assessment tools available.[23]

Pharmacological Treatment:

Treatment of burn pain is divided into pharmacolgical and nonpharmacological approaches. Pharmacologically, opioid agonists are the most commonly used analgesics. These drugs include morphine, hydromorphone, methadone, oxycodone, and fentanyl. **Although physical dependence is expected with prolonged use of opioids, psychological dependency (addiction) is rare in patients being treated for burn pain;** frequency of addiction in patients being treated for acute pain is estimated at 1 in 11,000.[24] Legitimate concerns regarding risks and side effects, as well as patient comfort issues, such as nausea and constipation, may limit the use of pharmacological interventions in burn care. Latarjet and Choinere[25] cited **fear of opioid side effects and addiction, in addition to the lack of adequate assessment and pain treatment protocols, as contributing to inadequate pain relief in children with thermal injuries. One role of the clinician is to assure patients that taking opioid analgesics is not a sign of weakness and that fears of addiction are unwarranted.** Opioid analgesics may be supplemented with other pharmacological approaches, including inhaled nitrous oxide and anxiolytics.[26] Lorazepam (Ativan, a benzodiazepine) has recently been found to lessen burn pain, largely by treating acute anxiety.[27]

Nonpharmacological Treatment:

Nonpharmacological pain control techniques include cognitive-behavioral interventions and hypnosis. In looking for effective techniques, it is important to determine a patient's natural coping style. **Coping styles can be divided into two broad categories: approach or avoidance. Patients who approach a stressful situation are also known as sensitizers; in a medical setting, they tend to cope by focusing their attention on the painful procedure.** Patients who avoid a stressful situation are also known as repressors. In contrast to sensitizers, they cope by turning their attention away from a painful procedure. Sensitizing patients can benefit from coping strategies that allow them to reinterpret the meaning or sensation of their pain or become actively involved in their care. **Repressing patients are likely to benefit more from approaches that allow them to dissociate from their experience, such as deep relaxation and imagery.[28]** These two styles anchor opposite ends of a proximity of care continuum (Figure 1). Interventions should be matched according to coping style.

A brief description of some of the nonpharmacological interventions follows, starting with interventions on the repressor or avoidance end of the continuum and working through to the sensitizing end of the continuum.

Figure 1

PSYCHOLOGICAL TREATMENTS FOR BURN PAIN ALONG A "PROXIMITY TO CARE" CONTINUUM

Psychologically Distant from Burn Wound Care	**1. Avoidance**	Hypnotic analgesia Guided imagery Distraction Thought-stopping and positive self-statements
↕	**2. Relaxation**	Positive emotion induction Breath control Muscle relaxation
	3. Operant Techniques	Regular medication scheduling Reducing residual pain behaviors Nonreinforcement of escape behaviors Reinforcement of good therapy performance
	4. Information	Preparatory pharmaceutical information Preparatory procedural information Preparatory sensory information
	5. Reappraisal	Reappraising the experience Correcting misinterpretation of procedures Correcting misinterpretation of painful stimuli
Psychologically Close to Burn Wound Care	**6. Participation**	Regulate the pace of wound care Help staff perform wound care Perform own wound care

Martin-Herz SP, Thurber CA, Patterson DR.Psychological Principles of burn wound pain in children: Part II:Treatment applications. *Journal of Burn Care and Rehabilitation*. 2000;21(5):458–72.
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Hypnosis/Imagery/Distraction

Hypnosis with burn patients is an appealing approach because it can be applied quickly, often with dramatic results. Patients in burn units seem to be unusually good candidates for hypnosis because they are emotionally regressed from trauma care, dissociated by virtue of sustaining a trauma, and motivated to comply because of their high levels of pain.[29] Hypnosis is best applied before a patient undergoes a painful procedure. Several controlled studies indicate that such an approach reduces reports of pain.[4,27,30] It is likely that children are more responsive than adults and can benefit as much or more from hypnotic analgesia.[23] It is important to note that hypnosis should only be implemented by psychologists, psychiatrists, or other mental health professionals who have received specialized training. A professional who has not been trained in other methods of pain control should not use hypnosis in this situation. **Although hypnosis can be highly effective, it may not always be the best method and the professional must be able to recognize when other interventions would be more appropriate. Since pain serves as a protective mechanism for our body, hypnosis should not be considered when the etiology of the pain has not been established. Hypnosis is also contraindicated if underlying emotional problems (e.g., emotional instability, personality disorders, dissociative disorders) could be exacerbated**

Guided imagery is another effective avoidance technique that can easily be learned by nurses, aides, and child life specialists. It is most likely to reduce pain through relaxation and distraction during painful procedures. For children, video games, reading, or listening to music may also be effective distraction techniques.[23]

Progressive Relaxation

Relaxation has been effective for background pain and in helping reduce tension created in the hospital setting.[8] It may also be used for patients who have difficulty sleeping. Relaxation can reduce tension and discomfort associated with medical procedures for both adults and children; however, use of relaxation for wound care has not been effective as the intensity of pain may overwhelm efforts at relaxation.

Operant Techniques

Basic operant behavior principles, such as reinforcing good therapy performance and not reinforcing escape behaviors, are effective in burn patients, particularly with children. An effective operant conditioning plan can also help reduce residual pain behaviors. Reward systems can be used for wound care and difficult therapy sessions. A good plan will include determining what motivates the patient and what can serve as rewards (i.e. walks, smoke breaks, movies, crafts). Reinforcement should be given immediately following the painful procedure. Next, the clinician and patient can develop a schedule for wound care and other painful procedures so that the patients knows what to expect and when. Finally, during wound care pain behaviors should be ignored and non-pain behaviors should be verbally reinforced.

Information

As dealing with fear of the unknown can be more difficult than dealing with reality, some patients cope better with more information. Information can be given to patients on details of procedures, upcoming surgeries, and sensory information during wound care (such as "this will sting," "this feels sticky," etc.).

Reappraisal

Cognitive techniques such as reappraising a painful situation or procedure can be effective for patients who fall toward the approach end of the continuum.[31] Explaining to patients that the sensations they are feeling indicate healing and regeneration of viable tissue may help the patient reappraise and accept the pain. **Associating the pain with positive effects can make it more bearable; it is helpful for patients to learn to discriminate hurt from harm and understand that burn pain of great intensity is always temporary.[32]**

Participation

For adults and children who cope by immersing themselves in a painful situation, allowing them to participate in their own wound care is important. This is particularly true for patients who like to be in control of their environment; simply being in the hospital takes away control and requires dependency. Allowing patients to determine their schedules and to perform as much of their own wound care as possible is important, and may decrease perceived pain by decreasing the uncomfortable nature of the environment and helping patients regain a sense of control over their body.

Quota System

Patients who experience prolonged hospitalization may begin to develop a syndrome of helplessness (similar to the "learned helplessness" coined by Seligman[33]) **that is marked by withdrawal, passivity, and anxiety.** The quota system is an approach to treating the helplessness phenomenon that has been successfully used in the rehabilitation and chronic pain fields.[34] **The goals of this approach are to help patients gain a sense of predictability and control while, simultaneously, minimizing the overwhelming nature of rehabilitation through systematic, gradual increases in expected behaviors.** The quota system begins with the taking of baseline measures for 3 to 5 days before the program is implemented. Targeted behaviors (which must be quantified and observed) can be any tasks that the patient feels are difficult or overwhelming. Common examples include sitting tolerance, walking, range-of-motion exercises, pressure garment use, and splint use. During the baseline phase, the patient is asked to perform the targeted behavior to the point of weakness, fatigue, or pain. Baseline is the average level tolerated during the 3-to-5-day period and serves as the basis for determining the initial value in the program. To promote early success, an initial value is chosen that is slightly lower (20%) than the average baseline performance. The amount of the exercises done are then increased each day to a new quota by consistent, predictable, attainable increments (5% to 10% of the initial value) so that increased tolerance is built gradually. **The patient is not allowed to exceed any of the quo-**

tas, even if he or she feels capable of working beyond tolerance. Ehde, Patterson, and Fordyce[35] reported the success of this approach on the burn unit.

Long-Term Rehabilitation

The long-term stage of recovery typically begins when patients leave the hospital and begin to reintegrate into society. For patients with severe burns, this stage likely involves continued physical rehabilitation on an outpatient basis, along with the possible continuation of procedures such as dressing changes and cosmetic surgery. This is a period when patients slowly regain a sense of competence while simultaneously adjusting to the practical limitations of a burn injury.

Studies have shown that the first year after hospitalization is a psychologically unique period of high distress.[1] Patients face a variety of daily hassles during this phase, such as compensating for inability to use hands, limited endurance, and severe itching. Scarring can also create significant difficulties for patients during this time, even a burn injury that has been grafted has the potential for scarring. Burn injuries at any joint have the potential to result in impaired mobility. As scar tissue covering a joint contracts, flexibility is increasingly compromised. Splinting, vigorous stretching therapies, and surgical releases are often necessary to maintain mobility. Severe burn injuries can also result in amputations, neuropathies (diseases of the nervous system, esp. cranial or spinal nerves), and heterotopic ossification (calcification of the joints that can impair range of motion).[36] All of these complications can result in permanent disfigurement and have an emotional and physical effect on patients, regardless of the size or location of the burn injury.[37] In addition to the high demands of rehabilitation, patients must deal with secondary stressors including family strains, return to work, and disruptions in daily life. A significant number of people may also continue to have vivid, distressing memories of the accident. Any symptoms of depression or anxiety disorders should be treated.

Many of the symptoms that escalate in the first year after a burn injury may be transient. Symptoms of anxiety and depression tend to decrease after one year post-injury.[1] In addition, there is evidence of improvement over time in adjustment to burn injuries, quality of life, and self-esteem, independent of the size of the burn injury. For a small number of patients, distress continues after one year; these patients should be diagnosed and treated accordingly. There has been very little research conducted on specific treatments for anxiety or depression with patients with burn injuries. Most clinicians will rely on standard treatment approaches for depression and anxiety, including cognitive-behavioral therapy and medications. **Predictors of lower quality of life after one year post-injury include a limited range of motion and lasting decreased functional capacity, as well as problems with noncompliance during hospitalization and reliance on avoidant coping styles. Social support has been found to serve as an important buffer against the development of psychological difficulty.[38]**

Vocational Adjustment:

Patients often undergo significant outpatient recovery before being able to return to work. Some patients choose to change jobs, but others experience undesirable changes in employment status such as a job reassignment or reduced work time. **Approximately 50% of burn patients require some sort of change in job status.[6] A significant number of patients experience vocational challenges, which make a vocational counselor a valuable member of the burn team.** A recent study showed that 66% of burn patients returned to work within 6 months after the injury; by 1 year, 81% of patients had returned to work.[39] As expected, patients who sustained larger burns take significantly longer to return to work.

Although no studies have been conducted to date, our clinical experience has shown that the sooner a burn survivor returns to work, the better their adjustment and satisfaction with life. Of course, they may need to start gradually at a limited capacity, and if they were burned on the job, they may need counseling or support to overcome any anxiety or fears they have regarding their injury. Success on the job can increase self-esteem and decrease levels of depression and it can also be an important part of physical and occupational therapy. When patients do no return to work they are less active and become deconditioned.

In the long term, social interaction patterns often change; and survivors often spend more time socializing with the family and less time interacting with people outside the family. There is little evidence that burn injuries lead to increased marital conflict in married burn victims. However, decreased sexual satisfaction is a common finding among burn patients, especially women.[1]

Treatment:

Adjustment difficulties that persist after one year post-discharge usually involve perceptions of diminished quality of life and lowered self-esteem. Some studies[1] suggest that a general trend of the impact of burn disfigurement is decreased self-esteem in women and social withdrawal in men. The Changing Faces program in Great Britain has been successful at enhancing self-esteem.[40] This program includes a hospital-based image enhancement and social skills program, along with a series of publications for patients that deal with aspects of facial disfigurement. The inpatient image enhancement program focuses on methods such as corrective cosmetic techniques, color analysis, and clothing coordination. Outpatient behavior and social skills training can help the burn survivor develop practical communication strategies to deal with difficult social situations and can help prevent social isolation.[40]

It can be helpful to make follow-up phone calls to patients after discharge or to continue to see patients in the outpatient clinic to screen for symptoms of distress and provide psychotherapy. Ancillary resources such as support groups and peer counseling by burn survivors can also be important services. Major burn centers ideally have a network of burn survivors who are willing to talk with patients in the hospital. Peer counseling can be particularly helpful for burn patients who have had little exposure to, or inclination to work with, mental health professionals. Support groups for patients and family members, either on an inpatient or outpatient basis (or both), can be immensely helpful.

Pediatric Burns

Family Issues:

Because over half of the burns in the United States affect children, it is important to examine some of the issues specific to the pediatric population. First, the family becomes even more important when dealing with pediatric patients. **Often, interventions are directed at the parents to teach them to participate in wound care and therapies; parents are vital to the burn care and rehabilitation of their child. Unfortunately, the pediatric burn literature has suggested that parents of children with burns have substantially higher rates of dysfunction than the general population.[41,42] One study found that 36% of families in which a child has sustained a burn injury had at least one parent with significant dysfunction,** including history of substance abuse, involvement with Child Protective Services, incarceration, or a psychiatric history. **Further, 29% of these children over the age of 4 had significant dysfunction (physical or sexual abuse, psychiatric disorder, behavior problems, or learning disability). Therefore, psychological interventions should be focused on parents as well as children**, assuming that there are parents who are present and able to be at the hospital. **Burn injuries should be regarded as a symptom rather than a cause of psychosocial problems in the family.** [43,44] **Although parent training may be indicated, not all parents will be receptive to this intervention. Hospitalization of a child is a very stressful time for families and parents may be too overwhelmed for any intensive therapy.** However, it may be a good opportunity to teach parents about burn and injury prevention, to educate them about disorders such as ADHD, and to make referrals to community support agencies who can aid parents by providing supervision of the child or outpatient counseling. **If there is ever any suspected physical or sexual abuse, or if the cause of the burn injury is suspect, child protective services should be notified immediately to investigate and make recommendations.**

Treatment:

Pain Control

As with adults, pain control will be a primary issue. Children experience the excruciating pain involved in acute burn care just as adults do. Unfortunately, young children do not have the cognitive capacity to understand the necessity for daily wound care. **Historically,**

children have been undermedicated for pain. There are several probable factors, including caution on the part of the medical staff not to overdose narcotics, and a child's inability to verbalize when in pain or to request pain medications. **Behavioral indicators such as crying, avoidance, withdrawal, and fear should be used to determine if a child is not properly medicated. The nonpharmacological interventions described earlier in this chapter have been found to be effective in reducing pain in children and can be extremely important adjuvants to standard pharmacological analgesia.** Children have the same range of coping styles as adults and should be involved in their care, with consideration as to what is age appropriate. For example, even two-year olds can help wash themselves (if they have more of an approach style, or can blow bubbles if they are avoiders).

Behavior Plans

With pediatric burn patients a thorough developmental history is crucial to prepare a good behavior plan, which should be implemented to avoid any anticipated behavior problems. These behavior plans should address the specific needs of each individual, but basic components can be applied to all children, which include:

- **Having a primary nurse assigned to work with the child**
- **Creating a consistent schedule so the child can prepare for treatments and therapies**
- **Having clear expectations/rules**
- **Enforcing logical consequences when rules are broken**
- **Providing considerable positive reinforcement for good behavior or getting through wound care, therapies, etc.**
- **Providing limited choices for the child (2 or 3 options) that can enhance the child's control over the environment.**

Consistency among the staff is important in implementing the behavior plan. Having a behavioral plan for a young inpatient can also aid parents in their attempts to establish a normal routine and environment once the child returns home. If the child is spoiled unnecessarily in the hospital, free of schedules and rules, then behavior becomes that much more difficult to control upon returning home.

Post-Trauma Adjustment:

There is little consensus concerning adjustment in pediatric burn patients. Studies are wrought with poor methodology and most studies have failed to assess premorbid psychopathology. There do seem to be fewer problems with adjustment than anticipated or expected by investigators. **The patient's age, stage of development, and relationship to the primary caregiver all influence reactions; a parent's adjustment also plays an important role in how children adjust psychologically to a burn injury.** In general, rates of psychopathology after a burn injury, as determined by DSM criteria, range from 15% to 20%. As in the literature on adult burn survivors, there seems to be no relationship between burn severity and psychological outcome. Time since the burn injury seems to mitigate maladjustment; in other words, distress symptoms decrease significantly one year after the injury. There also seem to be few problems with self-esteem after a burn injury. **Premorbid psychopathology in the parents and/or the child seem to be the biggest factor in predicting post-burn adjustment.**[43,44]

Although few patients meet full DSM criteria for disorders, 10% to 50% of patients will show symptoms of distress, typically symptoms of anxiety or depression that include sleep disturbance, nightmares, poor appetite, and an exaggerated startle response. It is important not to ignore the symptoms of distress and to provide appropriate treatment.

Children's behavior may regress while they are being treated on an inpatient basis. For example, toddlers who were previously toilet trained may require diapers, and older children may have periods of enuresis (involuntary loss of urine). These regressive behaviors are not predictive of future behavior or adjustment.

Return to School

The return to school will be a primary issue for children. After discharge from the hospital, many children need to wear splints and pressure garments to school. One study showed that children return to school an average of 7 days after discharge and miss an average of 22 school days. **The study also noted that children had relatively little loss of function and did not suffer academically. As expected, children with problems in school before the burn injury had problems after the burn injury.**[45] Return to school can be facilitated with school reentry visits, phone calls, and written materials to prepare school administrators and classmates for the patient's return.

Summary

A burn injury and the subsequent treatment is one of the most painful injuries a person can experience. Patients may undergo a lengthy hospitalization marked by surgeries and painful procedures and outpatient treatment can last for years after discharge. Yet, the emotional needs of patients with burn injuries have long been overshadowed by the emphasis on survival. Early outcome studies were often driven by medical models that assumed that the nature and size of a burn injury would predict emotional impact. Consequently, powerful determinants of emotional outcome such as preinjury adjustment or social support were often ignored. Current research indicates that the nature of a burn injury alone has little to do with how well a patient eventually adjusts. Adjustment to a burn injury appears to involve a complex interplay between the preinjury characteristics of the survivor, moderating environmental factors, the nature of the injury, and medical care.

Psychological distress during and after hospitalization may be likely in cases in which emotional dysfunction preceded burn injury. Once hospitalized for burn care, patients often experience transient emotional distress, independent of their premorbid status. Depression and anxiety symptoms commonly co-occur during the acute phase of recovery and may persist for the first year after discharge, but they do not occur at a higher rate in burn survivors relative to other hospitalized patients. Delirium, which is usually confined to the critical phase of recovery, and PTSD or ASD symptoms, which may persist during the acute phase and after discharge, are more commonly seen in burn patients, but tend to be relatively transient. Overall, for the majority of people hospitalized, a burn represents a painful but temporary disruption of life's routine. After injury and treatment they eventually resume normal preinjury functioning, which is largely independent of burn area or location. However, for the subgroup of patients who have been found to experience long-term disruption in social, vocational, and physical functioning, services such as long-term psychotherapy, vocational counseling, and intensive outpatient physical rehabilitation should be considered.

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Questions Based On This Lesson

To earn CE credits, answer the following questions on your quiz response form.

41. Which one of the following is a predictor of long-term adjustment to a burn injury?

A. The etiology of the burn

B. The size of the burn

C. Premorbid level of functioning

D. All of the above

42. Which one of the following would be appropriate pain control interventions for someone who is a repressor?

A. Hypnosis

B. Imagery

C. Distraction

D. All of the above

43. What issues should be addressed with patients during the resuscitative phase of recovery?

A. Teaching appropriate coping strategies

B. Examining causes of the injury

C. Listing long term consequences of the injury

D. Protecting a patient's natural defense mechanisms

44. Which one of the following statements is correct about pediatric burn injuries?

A. Burn injuries should be regarded as a symptom rather than a cause of psychosocial problems in the family.

B. Approximately 75% of pediatric burn patients come from dysfunctional families.

C. More than half of children over the age of 4 with burn injuries have significant premorbid dysfunction.

D. None of the above

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Directions in Rehabilitation Counseling

Volume 12 Lesson 12

Promoting Adaptive Goal-Seeking Strategies for Consumers With Borderline and Related Disorders

Alan Davis, PhD

Alan Davis is a Professor and Coordinator of Rehabilitation Education at Montana State University, Billings, MT.

Introduction

Writers in the field of rehabilitation have reported diverse challenges facing clients with a variety of psychiatric disabilities, including deficits in social skills. In addition to the emotional and behavioral symptoms associated with psychiatric conditions, many professionals report that psychiatric disabilities often occur in conjunction with other disabilities, thus complicating the adjustment process.[1-3]

An area of growing interest in the field of psychiatric rehabilitation is the question of how to effectively serve the needs of consumers with personality disorders.[4] The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) describes **10 specific types of personality disorders including *paranoid, schizoid, schizotypal, antisocial, borderline, histrionic, narcissistic, avoidant, dependent, obsessive-compulsive*, and *passive-aggressive*.**[5] Perry and Vaillant[6] pointed out that diagnosing personality disorders involves four important criteria:

1. **The client experiences maladaptive and rigid responses to stress**
2. **The client experiences significant impairment of work and intimacy**

3 **The client experiences conflicts in interpersonal relationships**

4 **The client's behavior is repeatedly a cause of annoyance and irritation for others.**

Personality disorders present a serious threat to an individual's ability to live independently, pursue gainful work activity, and maintain ongoing adaptation to community life.[7-10]

Personality disorders are associated with maladaptive strategies of interpersonal exchange such as seduction, manipulation, and aggression.[11] To encourage a successful rehabilitation outcome, counselors must help consumers/clients link their personal goals to the negotiation standard of social exchange that predominates in the labor market and in general social interaction.[12-19] To do this, counselors must be familiar with principles of negotiation and methods for promoting their adoption. Counselors must also be resistant to maladaptive strategies which may be employed, as they are very likely to be targets of these approaches.

One area of special concern in the field of psychiatric rehabilitation is serving the needs of consumers with borderline and related personality disorders. This lesson focuses on the special challenges associated in providing rehabilitation counseling services to individuals with four selected personality disorders (known as Cluster B disorders), and illustrates methods for counselors to use in recognizing and resisting maladaptive goal-seeking strategies while simultaneously promoting the client to adopt a negotiation approach.

Cluster B Disorders

Four personality disorders are referred to in the DSM-IV under the heading of Cluster B. These specific conditions are characterized as dramatic, emotional, or erratic.[5] The best known of these conditions is the borderline disorder, characterized by unstable emotions, difficulty in making decisions, and unpredictability. Also included in the Cluster B category are histrionic disorder, involving exaggerated emotions and dramatic actions; narcissistic disorder, in which an individual tends to be self-absorbed, inconsiderate of others, and prone to angry reactions to criticism; and antisocial disorder, in which a person is aggressive, disruptive, and unconcerned with social conventions such as rules and laws.[9] Borderline and related disorders have proven especially challenging for rehabilitation professionals because of their association with emotions such as anger and fear.[20] **Anger and fear are important sources of resistance in counseling, and must be worked through.** Fear is challenging because it can produce reticence and aloofness, thus making it difficult to form a trusting relationship. Anger can lead consumers into destructive patterns of confrontation and hostility with the counselor.

Additionally, these disorders involve behavioral problems such as impulsiveness and interpersonal conflict. For these and other reasons, Cluster B personality disorders can be highly resistant to change.[8,21] Progress in promoting social adjustment of clients with Cluster B disorders would benefit society, as well as the clients carrying these diagnoses, who tend to be associated with other problems of supreme social importance such as child abuse and substance addiction.[22-27] Rehabilitation challenges associated with borderline and related disorders are presented in Table 1.

Goal-Seeking Strategies

Development of Goal-Seeking Strategies:

Social expectations are significant determinants of behavior and are reflected in a person's preferred strategies of goal seeking and interpersonal exchange. Beck[21] points out that cognitive themes "not only influence the content of interpretations and conclusions, but also form the basis for the characteristic strategies utilized by individuals and, particularly, the kind of social environment they will try to create for themselves (p. 26)." **Borderline and related personality disorders are identified with maladaptive goal-seeking behaviors. The social expectations of consumers with Cluster B disorders are based on core insecurities resulting in unmet needs in the areas of identity, well-being, and dignity.[11]** In many cases, these core insecurities stem from dysfunctional and abusive family histories. **On the basis of their experience, consumers have learned to expect that future relationships will follow unsatisfying patterns, and will only become manageable through the use of controlling strategies.**

Table I

REHABILITATION CHALLENGES ASSOCIATED WITH BORDERLINE AND RELATED DISORDERS

	Immediate	Intermediate	On-going	Eventual
	Lack of effective interpersonal skills to build a successful socially adaptive lifestyle	Inability to cope with the stress of real-life problems as they come up—tendency for situations to become relapse triggers	Avoidance of underlying emotional issues; reluctance to face unresolved conflicts and develop stable personality functioning	Inability to maintain a functional lifestyle as an extended pattern; failure to anticipate and prepare for major life-stage transitions
Borderline	perception of personal boundaries clarification of personal values interpretation of anger differentiate needs from others restrain impulses to act out	resist social comparisons anticipate feelings of self-pity anticipate flashes of anger restrain urges to control people focus on other's feelings let go of disagreements	define a free standing self-concept develop a sense of basic security seek balanced intimacy in relationships reduce the need for complete control accept and recognize autonomy develop the ability to trust others	form a stable career path prepare for "empty nest" anticipate social transitions slowing down period prepare for loss of spouse
Histrionic	self-control of social performances self-assessment of behavior suspend need for gratification identify personal rewards value of internal approval	specify short-term goals systematically solve problems recognize needs of others respond to feelings of others cope with loss appropriately	develop comfort with solitude take responsibility for feelings develop internal references seek balanced intimacy in relationships overcome feelings of insecurity	identify life patterns define social growth goals define terms of personal success slowing down period
Antisocial	self control of impulses anger management skills goal planning self-disclosure acknowledgment of feelings avoidance of conflicts	resist exploitative impulses exercises concept of forgiveness stay focused on goals task-related collaboration counter urge to prevaricate	successfully mourn loses accept personal limits acknowledge the value of others form and sustain commitments overcome feelings of victimization	accept family responsibilities anticipate changes in others define success in terms other than "power" and "control" slowing down period
Narcissistic	commitment to rehabilitation development of empathy acceptance of losses restraint of self-promotion self-control of temper	anticipate and cope with rage accommodate other's feelings make appropriate compromises acknowledge worth of others accept constructive criticism	explore fears of rejection and failure develop detailed identity seek balanced intimacy in relationships explore feelings of vulnerability acknowledge defensiveness	circumscribe personal goals receive mentoring provide mentoring anticipate the aging process prepare for retirement

Types of Goal-Seeking Strategies:

The range and relationships of interpersonal goal-seeking strategies can be shown using a model with two intersecting axes.[28-30] One axis is representative of strategies varying on a continuum from direct to indirect, the extent to which the individual's objectives are obvious or concealed. The other axis represents a unilateral/bilateral continuum of strategies, varying according to the extent to which the individual seeks goals in collaboration with others. The quadrants in this model represent negotiation (the culturally endorsed strategy); and seduction, manipulation, and aggression, which are the strategies often associated with Cluster B disorders.[31-34] The model appears in Table 1.

Negotiation strategies are rational and aim to achieve mutual gains; they include such approaches as persuasion, reasoning, and compromise. While negotiation-oriented strategies are considered more socially desirable, it is true that most people occasionally employ strategies from all four quadrants. Seduction strategies are aimed at winning a person's confidence and involve methods such as dropping hints, flattery, and bribery. Manipulation strategies are designed to achieve covert control of others, and utilize such methods as sabotage, deception, and withdrawal. Aggression strategies are intended to control by whatever means are available, and include threat, assault, and pronouncement of fait accompli. Relationships with individuals with Cluster B personality disorders are complicated by a pronounced and consistent preference for strategies from the seduction, manipulation, and aggression groups.

Seduction

The defining methodology of seduction is the winning of approval and trust from the person targeted for seduction. Seduction is a covert strategy and its success depends upon the targeted person remaining unaware of the factors influencing them. Use of the principle of ***similarity*** is one fundamental aspect of seduction; people tend to be more comfortable and trusting in relationships with those perceived as similar to themselves. Thus, the individual using seduction as a strategy may attempt to win confidence by portraying values and standards considered important by the targeted person. As part of this presentation, an individual using seduction may also attempt to appear interesting and competent according to the standards of the individual being seduced. **People who employ seduction as a strategy understand that people have a tendency to assign positive traits, such as intelligence, kindness, and honesty, to those who are attractive. Accordingly, a seduction strategy may include efforts to appear physically attractive through careful attention to grooming and attire. The seduction strategy may also aim to create a wish for intimacy in the person being seduced, so that they will be more open to influence, and more likely to provide attention and substantial rewards.**

Familiarity is another principle that is fundamental to a seduction goal-seeking strategy. We tend to feel comfortable and trusting in the presence of those with whom we are most familiar. A person using a seduction strategy will try to have a high rate of contact with the person being seduced to increase relaxation and enhance the perception of working toward shared objectives. Another ploy designed to increase familiarization is association with events and persons known to be trusted and respected by the person being seduced; a person using seduction will try to appear connected with positive events and persons. This strategy takes the form of name-dropping, basking in reflected glory, and interpretation of actions and decisions in "we–they" terms. Additionally, the person using seduction strategy will downplay links to failure.

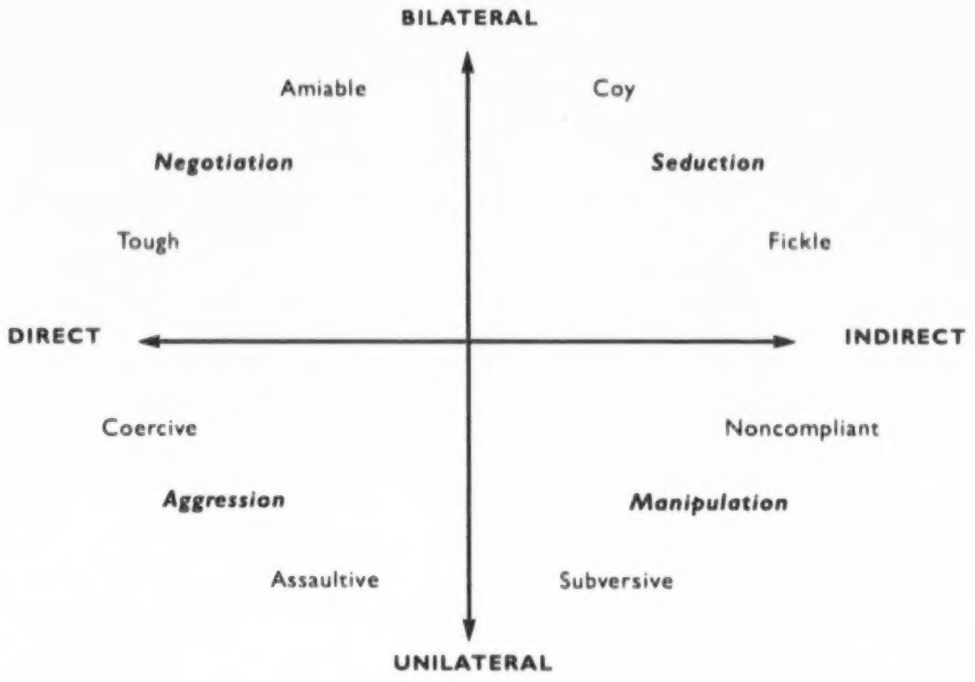
A primary characteristic of seduction is the use of flattery and compliments. Therefore, **seduction strategy employs careful use of observation to identify the emotional needs of the person being seduced;** the seducer will observe any aspect of the targeted individual that attracts attention and offer compliments. The response to compliments will be watched carefully and used to gain further insights into the emotional needs of the targeted person. Seduction strategy may also move in a sequence from mild criticism to compliments, to encourage the targeted individual to engage in a behavior pattern of striving for inclusion.

Coyness and Fickleness

One marginal style of seduction is coyness, which is more bilateral than indirect. A person behaving in a coy

Figure 1

DIMENSIONAL MODEL OF GOAL-SEEKING STRATEGIES



manner is not often dishonest regarding values, but tends to be coquettish and superficial in relationships. Coy behavior is flirtatious and prone to dalliance with the feelings of other people, and a characteristic problem resulting from coyness is a tendency for weak commitments. The other marginal style of seduction involves fickle behavior, which is more indirect than bilateral. A fickle goal-seeking style influences others by being overly sensitive and exaggerating anger or hurt feelings. Because the fickle approach involves moodiness, individuals employing this strategy are characteristically elusive and prone to withdrawal.

Detecting and Counteracting Seduction:

An important beginning point in counteracting seduction is the discovery that a covert process is occurring. Awareness of seduction can begin by noting whether we are attracted to someone more than we ordinarily would be; **if someone seems too marvelous to be true, than they probably are emphasizing desirable qualities for their gain.** Watch for the halo effect. It is also important for the counselor to notice if their affairs are construed in polarized terms. **Specifically, note whether someone is encouraging you to engage in an increasing amount of "we versus they" thinking. Such a perception can reduce one's openness to feedback and constructive criticism, and lead away from a win-win orientation.**

Another method for reducing vulnerability to seduction is to make a habit of depersonalizing decisions. **Practice separating your impressions of individuals from the decisions or actions they urge you to consider;** would the proposal look as good on its own merits, apart from the individual making the proposal? Inform the consumer that good planning requires "thinking outside the box" as an attempt to foresee possible pitfalls. **Invite the consumer to criticize his or her own proposal while you play the devil's advo-**

cate. If they are unable to identify any possible flaws, determine why not. If they can, notice whether there are expressions of anger or fear in vocal tone, facial expression, or body language.

Manipulation

The goal of manipulation is to achieve a high level of interpersonal control while at the same time remaining undiscovered, thus minimizing the chances of open conflict. A person employing manipulation as a goal-seeking strategy will attempt to influence people, but simultaneously avoid actions that might expose a covert agenda. **Therefore, a person using manipulation will avoid direct confrontation and tend to resist disclosure of motives, goals, and feelings.**

There are many goal-seeking approaches available to someone who does not feel obliged to be self-disclosing. **Among the approaches most difficult to detect is the tendency to simply not be very supportive of any enterprise. Delay at critical times, caused by putting off actions or decisions, can be a method to guarantee failure.** A person using manipulation may resist passively by ignoring selected rules, standards, or procedures.

Other manipulative strategies involve subtle alteration of important facts. A person may try to convince you that there is a shortage of time, money, or some other critical commodity, so that an immediate decision or action is required without adequate time to reflect or explore alternatives. **A person using manipulation may feign emotional fragility to reduce the possibility of being confronted.**

The exacerbation of conflict is yet another strategy of manipulation. A person may try to pit people against each other by encouraging splitting;[32] this usually requires an accurate perception of the needs and insecurities of other people. Clever baiting, selective disclosure of inflammatory information, or omission of helpful information may be used to encourage interpersonal conflicts.

In personal relationships a pattern of selective reinforcement may be used. **A person using manipulation may give a taste of reward and approval, then withhold reward to create a desperate need for approval in the person being manipulated.**[33] Another manipulative method is to covertly marshal resistance to teamwork by promoting cynicism and pessimism among associates. This is usually achieved through chronic complaining, subtle sniping, and negative predictions concerning team objectives.

Noncompliance and Subversion

A marginal style of manipulation is the noncompliant approach, which is more indirect than unilateral. The noncompliant approach typically involves covert attempts to be passive-aggressive. As described in the DSM-IV, this approach involves "...procrastination, forgetfulness, stubbornness, and intentional inefficiency, especially in response to tasks assigned by authority figures" (p. 733). Noncompliance is characterized by withdrawal from responsibility and a pattern of minimal participation. Noncompliant individuals will feign lack of knowledge when confronted with their behavior. Another marginal style of manipulation is the subversive approach, which is more unilateral than indirect. A person using subversion will attempt to remain undetected, but will take direct action to cause harm. As part of a subversive approach, an individual may be conspiratorial and attempt to promote factional splitting and sabotage, and may resort to prevarication if necessary to influence and control others.

Detecting and Counteracting Manipulation:

To resist manipulation, counselors must be familiar with their own emotional issues. Through self-exploration and an effective relationship with one's supervisor, a counselor can develop the ability to recognize familiar emotional issues when someone is attempting to make use of them. It is important to maintain an effective relationship with one's supervisor to obtain an independent perspective. Rehabilitation counselors must examine their feelings for a sense of emergency or desperation; if such feelings exist, ask whether they are genuine or manufactured.

Counselors should ask themselves how a situation would look to an impartial bystander. When in doubt, it is important to remember that we can take time to reflect before making a decision. For example, when a counselor is presented with a litany of complaints, it is best not to agree or disagree immediately. Agreement without reflection can result in being drawn into a negative emotional slide. **When negative points have been**

identified, the discussion can be shifted to a problem-solving mode with a focus on verifiable data. It can also sometimes be effective to describe the behaviors you observe when people are silent or selectively absent at critical points in problem solving discussions. Most importantly, counselors should be alert for clients who tend to speak to them in whispered tones.

Aggression

Aggression is the product of anger and the feeling of having been unfairly victimized. People using aggression as a goal-seeking strategy feel that they have been harmed. **The perception that one is the victim of an injustice can be attractive for several reasons: as a victim, one can enjoy a feeling of being freed from the tiresome requirements of compromise with others, who are now seen as unworthy. Additionally, self-perceived victim status confers an ongoing sense of personal entitlement in reparation for past injuries.** As a result, those who adopt this outlook will tend to place their own enjoyment or convenience above obligations to others. Additionally, they tend not to confide or reveal information, and will distort or withhold information to control the thoughts of others. The overall objective of a person using aggression is to "get even." **Perceiving themselves as victims, people who use aggression will characteristically try to maximize their own gains by whatever means are available, regardless of the needs of others. Persons who do not join them as allies in furthering their aggressive pursuits are ordinarily viewed as enemies.**

In interpersonal transactions, people who use aggression tend to be rigid and uncooperative. A standard aggressive tactic is to challenge the veracity of the statements, motives, or assurances of others.They present unrealistic bargaining positions and make no concessions. They note the weaknesses of others and use threats to frighten and control people. In discussions they are argumentative, intolerant, and impatient, and sometimes pose themselves as experts who refuse to listen. Bluffs and increasing demands are used to intimidate. **In relationships, people who use aggression are unrealistic, make insatiable demands on others, and, at times, can be highly critical of others.** If coercive measures such as verbal abuse are successful, they may escalate to physical assault. Because they feel that they have suffered unfairly, people who use aggression believe that their actions are justified, and are therefore capable of being ruthless, vengeful, and cruel without remorse.

Assault and Coercion:

The assaultive approach is a marginal style of aggression, one that is more unilateral than direct. **This approach is characterized by the physical attack to cause harm, by the lack of explanation of motives, and by the tendency for the aggressor to act suddenly, without warning; therefore, this approach is the most dangerous of the maladaptive goal-seeking strategies.** Another marginal style of aggression is the coercive approach, which is more direct than unilateral. The coercive approach favors verbal forms of aggression such as extortion, threats, and blackmail; this approach to aggression relies on the effectiveness of fear in rendering others vulnerable.

Detecting and Counteracting Aggression:

To counter aggression strategy, one must stand firm against threats and bluffs. To avoid being at a disadvantage, counselors must resist being drawn into conflict on the other person's terms. **Counselors should maintain their support for a position as they understand it, and not let others define it. The counselor should not make excuses for the aggression, as this only encourages future aggression under similar circumstances.** It is important that the counselor respond in a firm but calm manner, and should leave the interaction if the other individual won't follow fair rules. To avoid danger it is important to leave a violent situation or have the aggressor removed. Most importantly, one must not succumb to the temptation to respond to aggression with the tools of aggression. Responding in kind will only contribute to the other person's feelings of victimization and entrench his or her position. When counteracting aggression one must be prepared for a sudden change: the consumer may perceive the counselor as someone who cannot be bullied, and may suddenly attempt to enlist the counselor as an ally.

Negotiation

Negotiation is a goal-seeking strategy based on an attitude of respect for the other parties involved. The primary defining aspect of negotiation is the objective of finding an outcome in which all participants benefit.[35,36] Negotiation requires conventional courtesies and fairness, since conflict is not conducive to a balanced outcome. A person using negotiation acknowledges the needs and concessions of others and uses a tactful approach in pursuing gains. **When using negotiation, a person must seek mutual gains, and be willing to make offers to secure concessions. Negotiation requires participants to trust each other's statements and promises. Put simply, negotiation is based on a norm of cooperation. A major objective of negotiation is to preserve a positive climate for future negotiations.**

Successful negotiators must have realistic expectations of each other, and will be perceptive and able to maintain self-restraint. Negotiating parties must share information openly and honestly. When mistakes occur in negotiation, the parties must be forgiving and preserve self-control for the negotiation process to continue.

The Tough and the Amiable Approach

A marginal style of negotiation is the tough approach, which is more direct than bilateral. The tough approach considers 'winning' a higher priority than mutual gains. When employing the tough approach to negotiation, an individual tends to offer few concessions and prefers to seek advantages. A characteristic of the tough approach is patient reliance on the ability to prevail.

Another marginal style of negotiation is the amiable approach, which is more bilateral than direct. Some people entertain self-doubt regarding fairness in negotiations. They may feel guilty about their objectives and become willing to risk being exploited if necessary to secure approval. The amiable approach relies on the ability to charm others and sacrifice gains. A common negotiation tactic is to make a unilateral concession to encourage the other side to reciprocate. While this approach may be generally effective at getting things moving, it can also result in vulnerability if the other side is tough and unwilling to reciprocate. **The person who has given a unilateral concession may feel victimized, resulting in a long-term pattern of overgenerosity followed by rigidity and defensiveness.** People who favor an amiable approach tend to be ineffective as negotiators, are easily taken advantage of, and prone to feelings of victimization resulting from unbalanced outcomes.

Promoting Negotiation:

Use of dysfunctional goal seeking strategies frequently occurs as a learned response to social situations in which the consumer experiences strong emotions such as anger and fear. These response patterns can be well established relational templates originating in childhood.[37] **An important first step in teaching negotiation skills involves helping the consumer develop the ability to reduce strong distracting emotions, so that social situations can be approached with an open mind. It can be helpful to encourage the consumer to notice physiological signs of emotional arousal and identify them as dysfunctional response triggers.** To teach self-control and social receptiveness, it may be helpful to carefully examine the relationship between the consumer's expectations of others, emotional reactions, and behavioral responses. **Learning to cognitively challenge negative expectations of others can be a key skill in avoiding overwhelming emotions and related behaviors. Consumers can practice a negotiation approach by being helped to anticipate social encounters in advance;** they can form a plan for how they would prefer to act in a negotiation dialogue and rehearse the interaction in their imagination. After interactions occur the events can be reviewed to evaluate how closely they matched the preparation scenario.

To encourage a negotiation approach, a counselor must help the consumer develop skills to identify win–win outcomes and explore the advantages of fairness as a value guiding interpersonal exchange. A problem-solving model can provide a helpful conceptual framework for creating win-win outcomes. One such model is the Added Value Negotiating approach for counseling.[38] It's steps are listed, as follows:

- **Clarify interests**
- **Identify options**
- **Design various solutions**
- **Select the best solution**
- **Evaluate and modify as necessary**

A problem-solving approach to negotiation is based on collaborative brainstorming of mutually attractive options. Problem solving aims to involve and make creative use of all parties in a negotiation. It is important to view the search for solutions as teamwork, and strive to make everyone heard. **Consumers can practice looking for the common interests of the negotiating parties. It can be helpful to practice paraphrasing the position of the other party as a means for developing commonality.** Effective paraphrasing can articulate a position and also highlight the important values and advantages of a position. **Another important skill is prioritizing values relevant to the negotiation,** so that it can be possible to compromise on terms of lesser importance, if that is necessary to reach an agreement.

Consumers must be persuaded to experiment with reciprocity, returning honesty and openness with the same. They must also be cautioned not to accept a concession or unilateral gift in a negotiation unless they intend to reciprocate; such gestures imply balanced exchange. Through experience, clients can develop the ability to trust their feelings regarding whether a pattern of exchanges is leading to mutual satisfaction, and they can learn to stop exchanges before they go too far in the direction of unfairness.

When negotiating, it is important to avoid personalizing rejections of offers or proposals. **When an offer must be turned down, one should be careful to reject the offer and not the person making the offer. An overriding consideration in negotiation is the need to preserve a climate of fair exchange.** With this in mind, the temptation to take advantage of an overgenerous negotiator must be resisted. An important skill is being able to evaluate possible options in terms of their capacity to endure as long-term sources of mutual satisfaction. Taking advantage of easy opportunities may lead to overly rigid negotiations in the future in the form of unwillingness to make reasonable compromises.

Summary

Borderline and related personality disorders are characterized by severe difficulties in maintaining satisfying and stable patterns of employment and interpersonal relationships. People with borderline personality disorders characteristically demonstrate maladaptive patterns of goal seeking that include seduction, manipulation, and aggression. It is not unusual for rehabilitation counselors to be the target of these approaches.

This lesson discussed the strategies of seduction, manipulation, and aggression and methods of recognizing and counteracting such approaches. The goal-seeking strategy of negotiation was described and recommended as a socially acceptable method of interpersonal exchange. The value of promoting negotiation as an approach to social exchange is important because of the vocational and community-adjustment emphasis of the rehabilitation process. Without success in promoting positive and productive patterns of interpersonal exchange for clients, it is unlikely that successful rehabilitation outcomes can be achieved.

It is recommended that rehabilitation counselors emphasize a problem solving model of negotiation. To help replace dysfunctional goal seeking strategies with a negotiation focus consumers can be taught important skills such as emotional self-control and open-mindedness, identification of mutual interests, articulation of another person's position and values, prioritization of values, and evaluation of long range durability of agreements. Most importantly, consumers with Cluster B disorders should be encouraged to value collaborative agreement as a higher achievement than simply winning.

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Questions Based On This Lesson

To earn CE credits, answer the following questions on your quiz response form.

45. Noticing that someone seems too good to be true may be an indication that you are the target of which strategy?

A. Seduction

B. Manipulation

C. Aggression

D. Negotiation

46. Manipulation is characterized by which pattern of behavior?

A. Bluffs, increasing demands, and intimidation

B. Giving a taste of reward, then withholding reward to create a desperate need for approval

C. Conventional courtesies and fairness

D. None of the above

47. A risk associated with unilateral concessions in negotiation is that they may not be reciprocated, and therefore eventually result in what type of reaction?

A. Insatiable demands

B. Tact and trust

C. Openness and respect

D. Rigidity and defensiveness

48. To promote a negotiation strategy, counselors can encourage consumers to engage in which behavior(s)?

A. Cognitively challenge negative expectations of others

B. Rehearse appropriate interactions in their imagination

C. Prioritize values relevant to the negotiation

D. All of the above